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DEVELOPMENTS IN AGING: 1984
VOLUME 1

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 354, MARCH 2, 1984

Resolution Authorizing a Study of the Problems
of the Aged and Aging

FEBRUARY 28 (legislative day, FEBRUARY 18), 1985.—Ordered to be printed

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LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC, February 28, 1985.

Hon. GEORGE BUSH,
President, U.S. Senate,
Washington, DC.

DEAR MR. PRESIDENT: Under authority of Senate Resolution 354, agreed to March 2, 1984, I am submitting to you the annual report of the Senate Special Committee on Aging, Developments in Aging: 1984, volume 1.

Senate Resolution 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging "to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing and, when necessary, of obtaining care and assistance." Senate Resolution 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

This report describes actions during 1984 by the Congress, the administration, and the Senate Special Committee on Aging which are significant to our Nation's older citizens. It also summarizes and analyzes the Federal policies and programs that are of the most continuing importance for older persons, their families, and for those who hope to become older Americans in the future.

On behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

JOHN HEINZ, *Chairman.*

SENATE RESOLUTION 354 (SECTION 19), 98TH CONGRESS, 2D SESSION [1]

SEC. 19. (a) In carrying out the duties and functions imposed by section 104 of S. Res. 4, Ninety-fifth Congress, agreed to February 4, 1977, and in exercising the authority conferred on it by such section, the Special Committee on Aging is authorized from March 1, 1984, through February 28, 1985, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable basis the services of personnel of any such department or agency.

(b) The expenses of the committee under this section shall not exceed $1,159,720, of which amount (1) not to exceed $35,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $1,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of such Act).

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[1] Agreed to March 2, 1984.

PREFACE

While aging issues remained at the top of the national agenda in 1984, few significant legislative initiatives were acted upon by the Congress. Concern over growing annual budget deficits continued to preoccupy the Members of Congress and preclude the consideration of costly or comprehensive legislation. Nonetheless, the Congress reauthorized the Older Americans Act, under which most of the social services for older persons are organized, and made marginal improvements in supplemental security income (SSI) and private pension benefits, coinciding with 10-year anniversary observances of the enactment of SSI legislation and ERISA.

The relative absence of major aging-related legislation in 1984 was, in part, the result of significant 1983 reforms in financing for the key entitlement programs—Social Security and Medicare. In 1984, for the first time in a decade, the Congress faced neither a short- nor a long-term financing problem in the Social Security Program. Moreover, new projections revealed a further delay in the impending Medicare financing crisis. Since the changes in Social Security benefits and taxes and the shift in Medicare from cost-based to prospective reimbursement for hospital services had only begun to phase into effect in 1984, the Congress deferred further reforms until results of the 1983 change could be assessed.

The continuation of economic recovery in 1984 brought good news to the elderly and also helped lessen the pressure for reform. The economic expansion that had begun in December 1982 continued during 1984. At the same time, inflation remained particularly low. While the elderly received only minimal Social Security cost-of-living adjustments (COLA's were only 3.5 percent in January 1984 and 1985), low inflation also brought relatively stable living expenses. Of particular advantage to the elderly was the slowdown in the rate of increase in health care costs.

The strong economy also helped the financing of Social Security and Medicare by slowing inflationary cost increases while employment gains added payroll tax revenues. Despite the continuation of economic recovery, Federal budget deficits remained troublesome in 1984—amounting to $174 billion for the fiscal year ending in September. Ironically, while the trust-funded income and health programs serving the elderly benefited from the economic recovery and contributed substantial surpluses to the Federal budget, the Congress began to consider cuts in these very programs to aid in reducing burgeoning budget deficits.

While attention in the near term is focused on correcting Federal budget deficits, demographic changes now underway promise to open great opportunities and pose tremendous challenges for our society and our Government in the years to come. The enormous demographic changes facing us in the future are familiar to anyone who is concerned with domestic social policy. The postwar babyboom generation, now in its twenties and thirties, will bring sudden and dramatic transformations to society as it continues to mature. The arrival of this generation at retirement age in the beginning of the next century may seriously strain our systems of health care, retirement financing, housing, and social and community services unless these systems can be redesigned in the interim to meet this challenge.

There is more going on, however, than simply a growth in the number of older Americans. The expectations of older Americans are changing as well. Increasingly, in our society, those facing retirement anticipate living 10 to 20 years in relatively good health with a secure and adequate retirement income. While the severe problems associated with old age—chronic illness, poverty, and social isolation—persist, these problems often are forestalled until very old age. The particularly rapid growth in the oldest old, however, may severely strain the systems designed to provide resources and care in old age.

From our perspective today, these trends appear to be more troublesome for the health care system than for our retirement income, housing, or social service programs. Federal retirement income spending, for example, which now comprises 7.1 percent of GNP, is projected to decline as a share of GNP over the next two decades, rising eventually only to current levels again by 2030. Federal health insurance expenditures, by contrast, are projected to consume increasing portions of GNP over the same period, rising from 2.7 percent of GNP today to 7.5 percent of GNP by 2040.

Projections of this magnitude make it clear that the principal domestic challenge facing the Congress today is that of controlling rising health care costs. Health care costs have been exploding since the early 1960's with annual cost increases double and triple the rate of inflation. National health expenditures overall have grown from 5.3 percent of GNP in 1960 to 10.5 percent of GNP today. Of particular concern to older Americans and the Congress is the cost and financial solvency of the Medicare Program. Even though Medicare's financial condition has recently improved, Medicare is projected to exhaust its trust fund reserves by 1994, and run massive deficits thereafter, without further changes in current law.

Medicare, as expensive as it has become to the taxpayer, is not adequately protecting the elderly from the tremendous burden of rising health care costs. While Medicare has been paying a steadily increasing share of the health care costs of the elderly since its enactment, it still leaves the elderly paying as large a share of their incomes for health care as they did before Medicare was enacted. In 1984, the elderly paid an average of $1,059 out-of-pocket for health care. This represents an average of 15 percent of the median per capita income of the elderly and an even greater share of income for low-income Medicare beneficiaries not covered under Medicaid. In light of the rising out-of-pocket health care expenses under Medicare, repeated proposals in the Congress to shift additional cost from Medicare to beneficiaries are a source of tremendous anxiety and uncertainty for older Americans.

The problems with health care for the elderly are not limited to Medicare financing alone. The possibility of long-term care for a chronic illness or functional limitation poses the greatest single threat to the economic security of all but the wealthiest older Americans. There is currently little help available to families or older individuals in either our public programs or through the private sector to pay for potentially expensive long-term care services.

Despite the importance of health care cost control for the elderly, efforts to contain these costs must be balanced with a commitment to maintain the quality of health care. The search for savings carries with it the danger that providers may be encouraged to eliminate valuable services and facilities, substitute lower cost and less effective procedures, or deny needed care to the elderly. In all our cost containment strategies, we must strive to assure that the elderly have equal access to a single, high quality system of health care.

The economic well-being of older persons also remains a serious concern. The poverty rate among the elderly continued to hover around 14 percent, where it has been for the last decade. At the same time, this stagnation in the elderly poverty rate indicates that as a group the elderly have faired somewhat better during the recession of 1981 and 1982 than the nonelderly, whose poverty rates continued to climb in 1983. The focus on the official poverty rate, however, clouds two significant differences between the incomes of the elderly and the nonelderly. First, though similar proportions of both groups have subpoverty incomes, the elderly were much more likely to have incomes just slightly above the poverty threshold. Second, certain subgroups of the elderly have unusually high poverty rates, particularly the very old, minorities, widows, and those who are sick.

The persistence of high poverty rates in the face of the immense Federal resources devoted to programs supporting older Americans is paradoxical. Unmet needs remain even though the public appears to have reached a limit in its willingness to expand funding for aging programs. This continuing need in the context of the increasing diversity in the health and economic status of the older population has prompted some policymakers to reexamine the use of age criteria alone as the basis for public benefits. As a result, there is a growing interest in directing public resources toward those most in need and away from those with substantial additional sources of incomes.

In 1985, the Congress will have the opportunity to review and reassess the most important aging programs on the anniversary of their enactment. The Social Security Program will be 50 years old in 1985 while Medicare, Medicaid, and the Older Americans Act will celebrate their 20th anniversaries.

The Senate Special Committee on Aging reached a milestone of its own in 1984, with the celebration of its 25th year of attention to the concerns of aging Americans. It proved to be a particularly productive year for the committee as we continued to expand our efforts to inform the public through committee prints, newsletters, and a series of hearings focused on the most pressing issues before the Congress. In many instances, members of the committee were able to successfully propose legislative initiatives intended to better serve older Americans as a result of the committee's work.

The report that follows discusses developments of concern to older Americans in 1984. The report surveys only Federal policies and programs. Readers of the annual report from previous years will note a substantial change in the format of this year's report. In particular, this volume now focuses exclusively on the major policy issues facing the Congress and the legislative activity on these issues in 1984. Demographic data which previously appeared as chapter 1 of this report, and as supporting data in other chapters, are now consolidated in a separate volume on aging trends. Background material which appeared in earlier years in several chapters has not been repeated this year. These and other changes are intended to make this report more informative and easier to use.

We are proud to acknowledge the dedicated work of the authors of this report, the staff of the Special Committee on Aging. This report is a synthesis of the working knowledge they bring to the service of the committee.

In sum, ours is a maturing population. As we near the beginning of the 21st century, the growth in the relative size of the older population willl require us to adapt our policies in work and retirement, health care, and social services in both the public and private sectors to meet the needs and expand the opportunities accompanying the promise of long life.

John Heinz,
Chairman.
John Glenn,
Ranking Minority Member.

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DEVELOPMENTS IN AGING: 1984

VOLUME 1

FEBRUARY 28 (legislative day, FEBRUARY 18), 1985.—Ordered to be printed

Mr. HEINZ, from the Special Committee on Aging,
submitted the following

REPORT

[Pursuant to S. Res. 354, 98th Cong.]

Part I

RETIREMENT INCOME

In 1984, after several years of concern about the costs and financing of retirement benefits, attention to retirement income issues abated. For the first time in a decade, as a result of the 1983 Social Security Amendments, the Social Security Program was projected to be financially solvent both for the immediate future and for the long term. The Railroad Retirement Program was also newly solvent in 1984 as the result of 1983 legislation. In other retirement programs, the improvement in the economy helped reduce some of the concern about costs. This favorable financing climate is expected to continue for several decades since Federal retirement program costs as a share of the national economy are in a period of decline until after the turn of the century.

Instead, to the extent that there was any activity on retirement income issues in 1984 it was focused on improving the fairness and equity of existing programs. Major legislation enacted in 1984 toward these ends focused on the Social Security Disability Insurance (DI) Program and on private pensions.

The Disability Insurance Amendments of 1984 were a belated response to 3 years of overzealous administration of the continuing disability reviews mandated by the Congress in the Social Security Disability Amendments of 1980. The 1984 amendments were an at-

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tempt to make the reviews of continuing eligibility for Social Security disability insurance benefits fairer and to limit administrative latitude in determining eligibility.

On the 10th anniversary of the enactment of the Employee Retirement Income Security Act [ERISA], the Congress focused some attention on the pension problems of working women and divorced and surviving spouses. The Retirement Equity Act of 1984 extended survivor's protection to spouses of workers vested in pensions, lowered participation standards to improve benefits for workers with discontinuous careers, and clarified the treatment of pension benefits upon divorce. Although the actual changes were marginal, the enactment of benefit improvements signaled a possible renewal of congressional interest in broadening the availability of employer-provided pension benefits.

While there was a monentary emphasis on entitlement and benefit improvements in the 98th Congress, there was also a growing concern about the size of the Federal budget deficit. Several proposals for retirement income modifications were discussed in 1984 to help reduce Federal spending or increase Federal revenues. These included proposals for reform of the existing Civil Service Retirement System [CSRS], proposals for a broad budget freeze including a one-time nonpayment of COLA's, and restrictions on tax-qualified private pension plans to increase Federal income tax revenues. The tax treatment of private pensions was also raised in the context of several proposals for broad reform of the Internal Revenue Code.

The course the 99th Congress takes toward encouraging the accumulation of adequate retirement income remains to be seen. Federal budget deficits and tax reform initiatives promise to dominate the congressional agenda in the early months of 1985. Thereafter, the Congress must agree to a design for a Federal pension plan to supplement Social Security for Federal employees brought under the Social Security system in 1984. The mix of retirement benefits and savings incentives the Congress provides for its own employees should offer important clues on the future course of Federal retirement income policy.

Chapter 1

SOCIAL SECURITY (RETIREMENT AND DISABILITY)

OVERVIEW

In 1984, the major congressional action in Social Security was focused on the Disability Insurance [DI] Program. After 3 years of intense controversy, Congress enacted the Social Security Disability Benefits Reform Act of 1984 [Public Law 98-460]. On the other hand, the Social Security Old-Age and Survivors Insurance [OASI] Program was the subject of comparatively less congressional attention in 1984. As a result of changes made by the 1983 Social Security rescue package, 1984 was the first year in a decade with neither short-run nor long-run deficits in the OASI and DI trust funds.

The DI legislation is designed to thoroughly reform the disability determination system, with particular regard to the process employed in reviewing the continuing eligibility of beneficiaries on the DI rolls. The keystone of the DI legislation is the establishment of a medical improvement standard. In the future, the Social Security Administration [SSA] cannot deny continuing eligibility to a DI beneficiary unless it is shown that the individual's medical condition or ability to work has improved. The standard is to be applied to all future reviews as well as all cases currently being adjudicated, and to many people who have appealed termination decisions in the courts, either individually or as part of class-action suits.

The comprehensive legislative package includes several additional reforms. For example, disability examiners must now evaluate the combined effects of a multiple impariments on an individual, and the guidelines for assessing mental impairments must be updated and revised to reflect advances in the fields of psychology and psychiatry. Continued benefits pending appeal to an administrative law judge [ALJ] are extended through December 1987 for DI beneficiaries, and are made permanent for Supplemental Security Income [SSI] Program recipients. The review process itself is improved, particularly in the areas of the collection of medical evidence, the employment of appropriate medical specialists in reviewing case files, and the proper use of consultative medical examinations.

The overriding purpose of the legislation is to protect current and future beneficiaries from the arbitrary termination decisions witnessed between 1981 and 1984, and to make the entire disability determination process more humane, reasonable, and fair. The implementation of this legislation will pose several complicated and important issues that will need resolution during the next 2 or 3 years. For example, who among those terminated since 1981 will be put back on the DI rolls, and what will be the role of the courts in the rereview process? Who among those currently on the rolls will be grandfathered due to the medical improvement standard, and what will be the termination rate once the reviews begin again? Finally, what balance will be struck between generosity and stringency in this program which has proven to be so mercurial in the past?

In addition to DI legislation, two specific Social Security issues did receive congressional attention. In June, the Congressional Panel on Social Security Organization, a commission mandated by the 1983 amendments, outlined a proposal to establish SSA as an independent agency headed by an Administrator appointed to a 4-year term by the President, with jurisdiction for the OASDI and SSI cash benefit programs. Shortly after the panel's report was issued, several legislative proposals were introduced in the House and Senate to establish an independent SSA governed by a bipartisan Board. One proposal included Medicare under the administrative domain of SSA; the others did not.

The second issue centered around the possibility that the 1985 cost-of-living adjustment [COLA] would be deferred until 1986. Under current law, COLA increases are postponed 1 year if the annual increase in the Consumer Price Index [CPI] does not reach the 3-percent level. Projections that the 1984 CPI could be less than 3 percent led the President to recommend and the Congress to enact legislation to waive the 3-percent threshold for the 1985 COLA. Ultimately, this legislation was proven unnecesary, due to a jump in the CPI toward the end of the 1984 accounting period. Social Security beneficiaries were guaranteed a 3.5-percent COLA in January 1985.

Looking into the future, the OASDI funds appear solvent under current forecasts. They have performed better than anticipated because of the strength of the recent economic recovery. There is no guarantee, however, that the program will remain financially healthy indefinitely. Economic deterioration, worse than that forecast by the Social Security actuaries in their most pessimistic scenario, could conceivably force the Congress to address another short-term financing problem before the decade is out. In the long run, Social Security will always be subject to review and modification as the Congress strives to achieve a balance in the program between the interests of those paying taxes and those receiving benefits.

Finally, it is important to note that Social Security is a political and not only a financial institution. Therefore, it is possible that Congress may look to Social Security as a source of savings to reduce the Federal deficit, regardless of the financial health of the system. In the coming years, deficit reduction efforts are likely to include proposals to cut, delay, or reduce annual cost-of-living adjustments [COLA's], to further tax benefits, and to modify the benefit formula for future beneficiaries.

A. SOCIAL SECURITY—OLD AGE AND SURVIVORS INSURANCE

1. Issues

(A) THE STRUCTURE AND PURPOSE OF SOCIAL SECURITY

Enacted in 1935, the Social Security Program was designed to begin as a modest program with a relatively low tax rate and grow in stages until it reached maturity in the 1980's. As its architects anticipated, Social Security has only recently come of age, with the first generation of lifelong contributors retiring and beginning to draw benefits. While Social Security has expanded and changed substantially over the course of its development, the basic principles which guided the framers of the old-age pension program in 1935 have remained unaltered.

The design of Social Security reflects a compromise among a variety of purposes. This compromise is both a key to the program's broad-based political support and a cause of much of the criticism it receives. For while Social Security provides a mixture of insurance protection, earned pension benefits, and minimally adequate income in old age, it must make separate concessions in the value of each to achieve a combination that works. One current method of criticizing the program has been to evaluate the quality of benefits from only one perspective. For instance, many point to the possibility that rates of return on Social Security taxes paid by the highest wage earners may, in the long run, compare poorly with the rates of return on private investments. While it may be popular when discussing Social Security with a younger worker to focus on only one aspect of the system, this results in a distorted evaluation of the larger purposes of Social Security.

To ensure an accurate picture of the program, there are a number of features that should be factored into any equation which attempts to measure the value of Social Security.

First, Social Security provides younger workers with protection from the unpredictable and random costs of financial support for their own aged parents and relatives. The pay-as-you-go financing for Social Security, seen from this perspective, uses periodic payments by younger workers to insure their own earnings against the cost of parental support. By spreading these costs across the working population, younger workers have a smaller, fairer, and more predictable financial burden, and their parents have a degree of financial independence. This aspect of the program justifies universal coverage, since exemptions from coverage permit individuals to pass to others the costs of supporting their own parents. It also justifies features which will provide adequate retirement and survivors benefits, so that younger workers will be fully protected from having to supplement the incomes of their relatives.

Second, Social Security provides workers and their families with a "floor of protection" against sudden loss of their earnings due to their own death, disability, or retirement. This insurance is intended to protect only a portion of the income needed to preserve the previous living standard of the worker and his family, and is to be supplemented through private insurance, pensions, savings, and other arrangements made voluntarily by the worker. Receipt of benefits is based on the occurrence of an insured-against event, such as retirement, which is determined by comparing the individual to some "test" or standard, such as the retirement or earnings test. Should the individual meet the test, benefits are then provided regardless of any income from other sources.

Third, Social Security provides the individual wage earner with a basic pension benefit upon retirement. Social Security benefits, like those provided separately by employers, are related to each worker's own average career earnings. Workers with higher career earnings receive greater benefits than workers with low earnings. Each individual's own earnings record is maintained separately for use in computing future benefits. The earmarked payroll taxes paid to finance the system are often termed "contributions" to reflect their role in accumulating service credits.

This mixture of features in Social Security has been the source of public confusion about the program over the years. The similarities between Social Security and a pension, for example, have led many people to believe that the system is funded, as a private pension might be, through workers' contributions invested in a trust fund account and used to pay benefits in the future. Others focus on the rate of return on contributions—as if Social Security were a form of individual investment.

A program with the essential social functions and multiple purposes of Social Security defies comparison with other financial or insurance vehicles. While a particular vehicle, such as an individual retirement account [IRA], may perform one function more successfully for some than does Social Security, no single vehicle could perform the unique combination of functions without approximating Social Security in its features. Most criticisms of Social Security, therefore, readily translate into criticisms of its mix of functions. For example, some critics believe Social Security ought to be only a pension plan, leaving the insurance and intergenerational support functions to specially tailored alternative programs. Others argue that Social Security should be a welfare program, providing basic benefits to the poor, and allowing middle and upper income workers to invest their earnings in private vehicles, such as IRA's. Though the use of separate programs would eliminate the compromises entailed in Social Security, it could also raise tremendously the total cost of performing all of Social Security's functions, and most likely jeopardize the widespread political support that has developed for the program.

The Social Security Program, which was created during the Great Depression, is only now becoming a mature social insurance program. The decade of the 1980's marks the first generation of lifelong contributors retiring and beginning to draw benefits. Also during this decade, it is expected that payroll tax rates, eligibility requirements, and the relative value of monthly benefits will finally stabilize at the levels planned for the system.

(B) FINANCING

(1) Financing in the 1970's

As recently as 1970, OASDI trust funds maintained reserves equal to a full year of benefit payments, an amount considered adequate to meet any disruptions in expenditures or income due to unforeseen economic fluctuations. When Congress passed the 1972 amendments to the Social Security Act, it was assumed that the economy would continue to follow the pattern prevalent in the 1960's: Relatively high rates of growth and low levels of inflation. Under these conditions, Social Security revenues would have adequately financed benefit expenditures, and trust fund reserves would have remained sufficient to weather economic downturns.

The experience of the 1970's was considerably less favorable than forecasted. High levels of inflation and slow wage growth increased expenditures in relation to income. The Social Security Amendments of 1972 had not only increased benefits by 20 percent across-the-board, but also indexed automatic benefit increases to the CPI. Inflation fueled large benefit increases, with no corresponding increase in payroll tax revenues due to comparatively lower real wage growth. Further, the recession of 1974-75 raised unemployment rates dramatically, lowering payroll tax income. Finally, a technical error in the initial benefit formula created by the 1972 legislation led to "over-indexing" benefits for certain new retirees, and thereby created an additional drain on trust fund reserves.

Recognizing that the financial status of the Social Security trust funds was rapidly deteriorating, Congress responded by enacting the Social Security Amendments of 1977. The 1977 legislation increased payroll taxes beginning in 1979, reallocated a portion of the Medicare [HI] payroll tax rate to OASI and DI, and resolved the technical problems in the method of computing the initial benefit amount. These changes were predicted to produce surpluses in the OASDI Program beginning in 1980, with reserves accumulating to 7 months of benefit payments by 1987.

Again, however, the economy did not perform as well as forecasts had predicted, and the long-term deficit remained. After 1979, annual increases in the CPI exceeded 10 percent, a rate sufficient to double payouts from the program in just 7 years. Real wage changes had been negative or near zero since 1977, and in 1980, unemployment rates exceeded 7 percent. As a result, annual income to the OASDI Program continued to be insufficient to cover expenditures. Trust fund balances declined from $36 billion in 1977, to $26 billion in 1980. Lower trust fund balances, combined with rapidly increasing expenditures, brought reserves down to less than 3 months' benefit payments by 1980.

The 96th Congress responded to this crisis by temporarily reallocating a portion of the DI tax rate to OASDI for 1980 and 1981. This measure was intended to postpone an immediate financing crisis in order to allow time for the 97th Congress to comprehensively address the impending insolvency of the OASDI trust funds. In 1981, a number of proposals were introduced to restore short and long-term solvency to Social Security. However, the debate over the future of Social Security proved to be very heated and controversial, and enormous disagreements on policy precluded quick passage of comprehensive legislation. At the end of 1981, in an effort to break the impasse, the President appointed a 15-member, bipartisan, National Commission on Social Security Reform to search for a feasible solution to Social Security's financing problem. The Commission was given a year to develop a consensus approach to financing the system.

Meanwhile, the condition of the Social Security trust funds worsened. By the end of 1981, OASDI reserves had declined to $24.5 billion, an amount sufficient to pay benefits for only 1½ months. By November 1982, the OASI trust fund had exhausted its cashable reserves and in November and December was forced to borrow $17.5 billion from DI and HI trust fund reserves to finance benefit payments through July 1983.

The delay imposed by the work of the National Commission deferred the legislative solution to Social Security's financing problems to the 98th Congress. But the Commission did provide clear guidance to the new Congress on the exact dimensions of the various financing problems in Social Security, and on a viable package of solutions.

(2) The Social Security Amendments of 1983

Once the National Commission on Social Security Reform reached agreement on its recommendations, Congress moved quickly to enact legislation to restore financial solvency to the OASDI trust funds. This comprehensive package improved financing by $166 billion between 1983 and 1989, and eliminated all of what had been estimated to be a 2.10 percent of payroll 75-year deficit.

The underlying principle of the Commission's bipartisan agreement and the 1983 amendments was to share the burden restoring solvency to Social Security equitably between workers, Social Security beneficiaries, and transfers from other Federal budget accounts. The Commission's recommendations split the near term costs roughly into thirds: 32 percent of the cost was to come from workers and employers, 38 percent was to come from beneficiaries, and 30 percent was to come from other budget accounts—including contributions for new Federal employees. The long-term proposals, however, shifted almost 80 percent of the costs to future beneficiaries.

The major changes in the OASDI Program resulting from the 1983 Social Security Amendments were in the areas of coverage, the tax treatment and annual adjustment of benefits, and payroll tax rates. Key provisions include:

Coverage.—All Federal employees hired after January 1, 1984 are now covered under Social Security, as are all current and future employees of private, nonprofit, tax-exempt organizations. State and local governments are prohibited from terminating coverage under Social Security.

Benefits.—COLA increases are now provided on a calendar year basis, with the July 1983 COLA delayed to January 1984. In the event that trust fund reserves do not equal a certain fraction of outgo for the upcoming year—15 percent until December 1988; 20

percent thereafter—the COLA will be calculated on the lesser of wage or price index increases.

Taxation.—One half of Social Security benefits received by taxpayers whose income exceeds certain limits—$25,000 for an individual; $32,000 for a couple—is now subject to income taxation. This additional tax revenue will in turn be funneled back into the retirement trust fund.

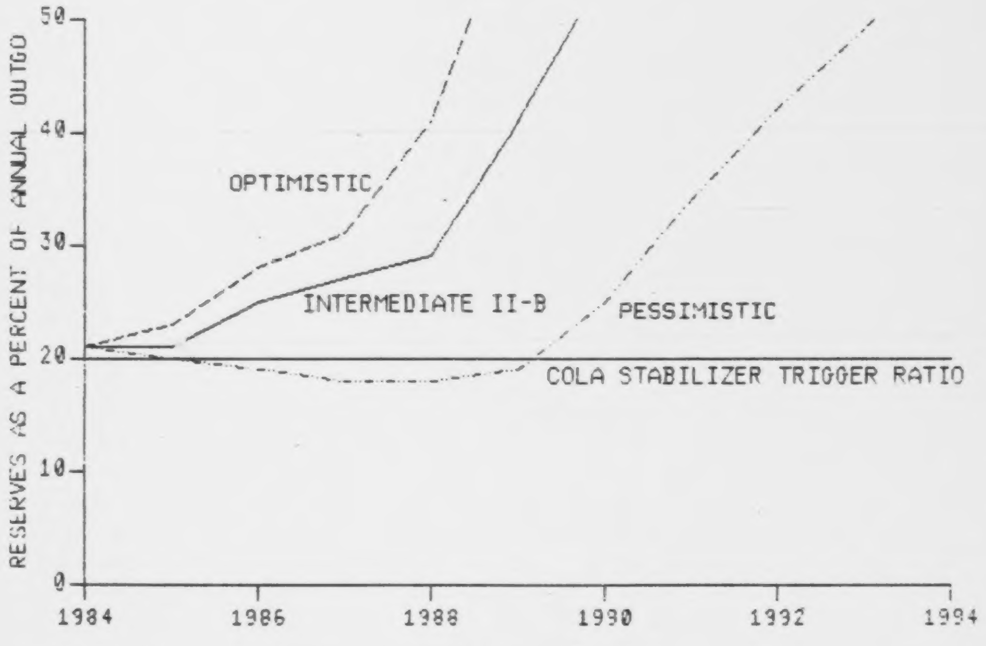
Payroll taxes.—The previous schedule of payroll tax increases was accelerated, and self-employment tax rates were increased.

Retirement age increase.—An increase in the retirement age from 65 to 67 will be gradually phased in between the year 2000 to 2022.

The 1983 amendments have resulted in a major improvement in the condition of the OASDI trust funds. Based on intermediate assumptions, it is expected that reserve ratios will increase from a low of 11 percent of annual outgo at the beginning of 1983 to 47 percent of outgo by the beginning of 1989. These reserves should be sufficient to continue uninterrupted benefit payments thoughout the decade, and repay the HI trust fund for previous loans.

CHART 1

OASDI RESERVE RATIOS UNDER ALTERNATIVE ASSUMPTIONS
1984-1994



SOURCE: 1984 OASDI TRUSTEES REPORT

(3) OASDI—Near-Term Financing

In the short term, OASDI funds are anticipated to increase steadily each year under all but the most pessimistic assumptions employed by Social Security actuaries. Under pessimistic assumptions, reserve ratios are expected to decline slightly, and then increase again in 1988. The short-range estimates reported in the 1984 Social Security trustees report are more favorable than those that informed the 1983 legislative efforts, due to the strength of the economic recovery, and actual economic experience has proven even healthier than the intermediate assumptions in the 1984 trustees report. Therefore it is conceivable that in the immediate future the trust funds will continue to grow faster than anticipated in the 1983 legislation. However, this financial growth could be partially hindered by an expansion for DI Program costs, due to legislation enacted in 1984.

Despite favorable economic performance, many argue that the short-term financing of Social Security does not leave a large enough buffer aginst unforeseen economic downswings, and that additional financing measures are necessary to guarantee continued solvency. For instance, in February 1984, the Committee for Economic Development [CED], a nonprofit, nonpartisan business research group, warned that the Social Security trust funds could encounter serious financial problems before 1990. In its report "Social Security: From Crisis to Crisis," CED argues that the range of basic assumptions that underpin the estimates provided by Social Security's actuaries fall within too narrow a spread, and are relatively optimistic given actual economic performance in the past decade. The upshot of the report is that unfavorable economic conditions—along the lines of the 1979–82 experience—could jeopardize the solvency of the trust funds, and that more benefit cuts are necessary to assure adequate reserve margins in the next 10 years.

Overall, the truly critical years in which reserves are slim are those between the present and 1988, when a major payroll tax increase goes into effect, and reserves will build rapidly. Between the present and 1988, under intermediate assumptions the 1984 Social Security trustees report predicts that reserves should remain between 20 and 30 percent of projected outgo. Under pessimistic assumptions, reserves will drop to 18 percent over the next 5 years, triggering a reduction in the January 1986 and 1987 COLA's under the automatic stabilizer provision mandated by the 1983 amendments.

Although the trustees consider their assumptions conservative, it is plausable to consider more pessimistic scenarios—yielding an imminent financing crisis. Each of the trustees' alternative forecasts assume slow but steady economic growth after 1985. The optimistic and intermediate alternatives assume the current recovery will continue through the end of 1984 and slow down thereafter. The pessimistic scenario assumes a mild recession in the first half of 1985, recovering to a period of real growth. It is important to note that economic performance since the issuance of the trustees' report in April has been more favorable than anticipated, and that most private economic forecasters project a continuation of the recovery, albeit at a slower pace, through 1985, with higher real GNP, and lower unemployment than the trustees' pessimistic assumptions.

While it is certainly possible that a serious recession could precipitate another financing crisis in the next few years, it is not clear that this potentiality justifies benefit reductions, particularly since this would add to the substantial OASDI surplus that will accrue after 1990 if the recession were not to occur. From a policy perspective, many argue that it is appropriate to delay benefit cuts until it is clear that they are necessary.

(4) OASDI—Long-Term Financing

In the long run, the Social Security trust funds appear to be in close actuarial balance, meaning that over the next 75 years, it is projected that the taxes collected for Social Security will fall within plus or minus 5 percent of the amount needed to pay benefits. Under current projections based on intermediate assumptions, the trustees predict that the trust funds will remain solvent throughout the next 75 years.

Although the OASDI trust funds remain healthy, under forecasts for the long term it should be emphasized that trust fund experience in each of the three 25-year periods between 1984 and 2060 varies considerably. In the first 25 year period—1984 to 2008—the trust funds are expected to accumulate rapidly, and maintain an annual surplus of revenues equal to 2.40 percent of taxable payroll. As a result of these surpluses, OASDI reserves are expected to build to over 250 percent of annual outgo by the year 2000.

TABLE 1.—COMPARISON OF ESTIMATED COST RATES AND INCOME RATES OF THE OASDI PROGRAM, ON THE BASIS OF ALTERNATIVES II–A and II–B, CALENDAR YEARS 1984–2060

[As a percentage of taxable payroll]

Calendar year	Cost rate			Income rate			Balance
	OASI	DI	Total	Payroll tax	Taxation of benefits	Total	
Alternative II–A:							
1984	10.15	1.15	11.30	11.40	0.19	11.59	0.30
1985	10.03	1.08	11.11	11.40	.20	11.60	.49
1986	9.96	1.05	11.01	11.40	.21	11.61	.61
1987	9.92	1.02	10.93	11.40	.23	11.63	.69
1988	9.87	1.00	10.87	12.12	.24	12.36	1.49
1989	9.80	.98	10.79	12.12	.26	12.38	1.59
1990	9.77	.98	10.75	12.40	.27	12.67	1.92
1991	9.74	.98	10.72	12.40	.29	12.69	1.97
1992	9.68	.98	10.66	12.40	.31	12.71	2.05
1993	9.63	.98	10.61	12.40	.32	12.72	2.11
1994	9.48	.98	10.46	12.40	.38	12.78	2.32
1995	9.31	.99	10.30	12.40	.38	12.78	2.48
1996	9.11	.99	10.10	12.40	.37	12.77	2.67
1997	8.89	.99	9.88	12.40	.37	12.77	2.89
1998	8.73	.99	9.72	12.40	.37	12.77	3.05
1999	8.60	1.01	9.61	12.40	.36	12.76	3.15
2000	8.48	1.03	9.51	12.40	.36	12.76	3.25
2001	8.38	1.06	9.44	12.40	.36	12.76	3.33
2002	8.30	1.08	9.38	12.40	.36	12.76	3.39
2003	8.23	1.11	9.34	12.40	.36	12.76	3.42
2004	8.17	1.15	9.32	12.40	.37	12.77	3.44
2005	8.14	1.19	9.33	12.40	.37	12.77	3.44
2006	8.13	1.23	9.36	12.40	.37	12.77	3.41
2007	8.16	1.27	9.43	12.40	.38	12.78	3.35
2008	8.20	1.32	9.52	12.40	.38	12.78	326
2010	8.38	1.38	9.76	12.40	.40	12.80	3.04
2015	9.35	1.48	10.84	12.40	.45	12.86	2.02
2020	10.60	1.53	12.14	12.40	.53	12.93	.79
2025	11.75	1.61	13.36	12.40	.60	13.00	–.36

TABLE 1.—COMPARISON OF ESTIMATED COST RATES AND INCOME RATES OF THE OASDI PROGRAM, ON THE BASIS OF ALTERNATIVES II–A and II–B, CALENDAR YEARS 1984–2060—Continued

[As a percentage of taxable payroll]

Calendar year	Cost rate			Income rate			Balance
	OASI	DI	Total	Payroll tax	Taxation of benefits	Total	
2030	12.48	1.58	14.05	12.40	.65	13.05	−1.00
2035	12.76	1.53	14.29	12.40	.68	13.08	−1.21
2040	12.64	1.55	14.19	12.40	.69	13.09	−1.10
2045	12.57	1.60	14.16	12.40	.71	13.11	−1.05
2050	12.67	1.60	14.28	12.40	.72	13.12	−1.16
2055	12.81	1.58	14.38	12.40	.72	13.12	−1.26
2060	12.85	1.56	14.41	12.40	.72	13.12	−1.28
25-year averages:							
1984–2008	9.07	1.06	10.14	12.22	.32	12.54	2.40
2009–2033	10.69	1.52	12.22	12.40	.54	12.94	.72
2034–2058	12.69	1.57	14.27	12.40	.71	13.11	−1.16
75-year average:							
1984–2058	10.82	1.39	12.21	12.34	.52	12.86	.65

Source: 1984 Social Security trustees report, p. 71.

In the second 25-year period—2009 to 2033—the financial condition of OASDI is expected to continue inproving in the early years, but begin deteriorating toward the end of the period. Trust fund reserves are expected to grow to over 500 percent of annual expenditures by 2015, and then decline, reaching 343 percent of outgo by 2035. The average surplus during this period will be only 0.72 percent of taxable payroll.

The third 25-year period—2034 to 2058—is expected to be one of continuous deficits. Program costs will grow until 2035 and level off, remaining above annual revenues. By the end of this period, continuing deficits are expected to have depleted the trust funds. Annual deficits over the 25-year period are expected to average 1.16 percent of taxable payroll.

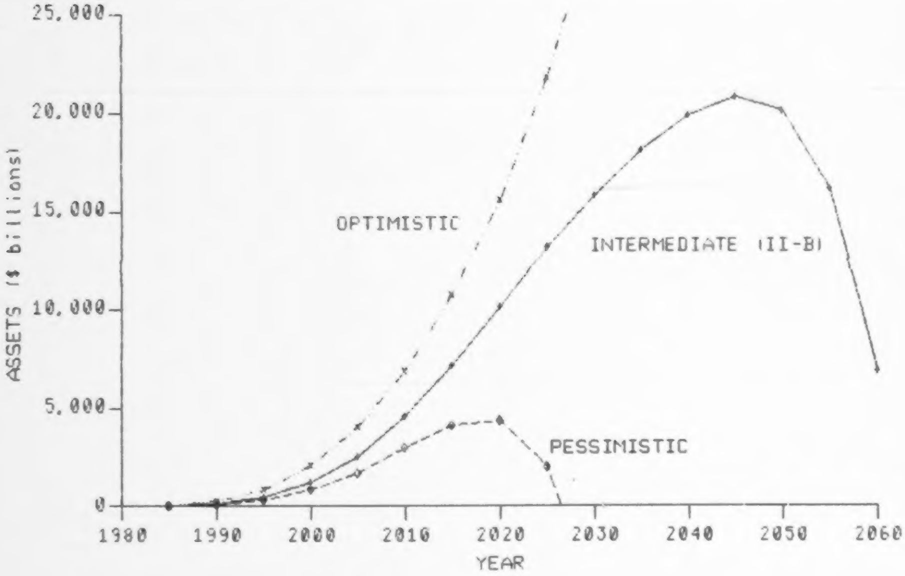
(a) Midterm surpluses

In the years between 1990 and 2025, it is projected that Social Security will receive in income far more than it must distribute in benefits. Under current law, these surpluses will be invested in interest-bearing Federal securities, and will be redeemable to Social Security in the years in which benefit expenditures exceed payroll tax revenues—2025 through 2060. During the years in which the assets are accumulating, these reserves will far exceed the amount needed to buffer the OASDI funds from unfavorable economic conditions. As a matter of policy, there is considerable controversy over the purpose and extent of these surplus funds, and the political and economic implications they entail.

During the period in which Social Security trust fund surpluses are accumulating, the surplus funds can be used, indirectly, to finance other Government expenditures or reduce the public debt. During the period of OASDI shortfalls, the Federal securities previously invested will be redeemed, causing income taxes to buttress Social Security. In essense, the assets Social Security accrues represent internally held Federal debt, which is equivalent to an exchange of tax revenues over time.

CHART 2

OASDI TRUST FUND ASSETS UNDER ALTERNATIVE ASSUMPTIONS
CURRENT DOLLARS
1980-2060



SOURCE: 1984 OASDI Trustees Report.

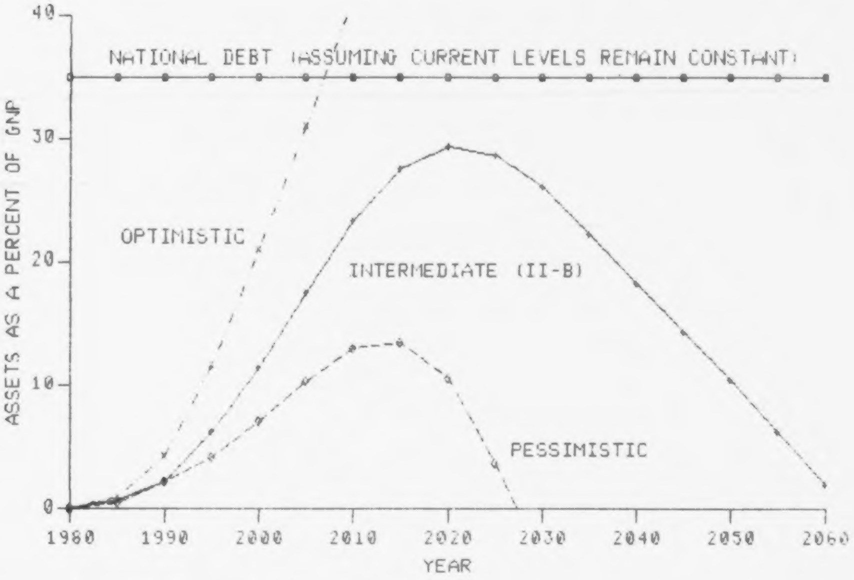
Though net effect on revenues of this exchange is the same as if Social Security taxes were lowered and income taxes raised in the 1990's, and Social Security taxes raised and income taxes lowered in 2020, the two tax methods have vastly different distributional consequences.

Social Security is financed by a regressive payroll tax, whose regressivity is justified on the basis that the benefit structure is progressive. The key policy issue is the significance of either scenario in the larger picture of the total Federal budget. In both instances, there is an incentive to spend surplus revenues in the 1990's, and cut back on underfunded benefits after 2020.

What will happen to the surpluses Social Security lends to the general fund? These funds will enable Congress to spend money elsewhere without raising taxes or borrowing. This money could be used to fund new Federal programs, reduce and possibly eliminate the budget deficit; or, with sufficient surpluses being to pay off the national debt. What will happen when this debt has to be repaid to Social Security? Either general revenues will have to be increased, or spending will have to be cut.

CHART 3

OASDI TRUST FUND ASSETS UNDER ALTERNATIVE ASSUMPTIONS
AS A PERCENT OF GNP
1980-2060



SOURCE: 1984 OASDI Trustees Report.

There are a number of alternative policy options for addressing the surplus/shortage problem. One choice would be simply to cut OASDI taxes in the coming decades, and encourage workers save privately for their retirement--for example, through tax favored IRA's—and reduce future Social Security benefits for those who do so. Alternatively, Congress could choose to create a floating tax rate, which would increase or decrease in direct relation to expenditures. This method would conform to the pay-as-you-go model of financing. Another option would be to direct a portion of the surplus OASDI revenues to the Medicare [HI] trust fund, which is expected to face severe financing problems in the coming years.

(b) Long-term deficits

The long-run financial strain on Social Security is expected to result from the problems of financing the needs of an expanding older population on an eroding tax base. The first part of this problem is that there are expected to be proportionately more older people, living longer, and continuing to retire early. Second, unusually high birth rates after World War II have already created a bulge in the population—the baby-boom generation—which is expected to reach retirement age beginning in 30 years. If life expectancy continues to rise and fertility rates stay low, as currently expected, the magnitude of this problem will be very great.

The relative increase in the number of beneficiaries per worker will not necessarily threaten the solvency of Social Security if productivity gains in the future compare to the experience of the past 30 years. Even though the ratio of workers to beneficiaries may decline, this can be offset by economic growth and increased real wages.

Another way of describing this is to point out that while the absolute cost of funding Social Security is expected to increase substantially over the next 75 years, the cost of the system relative to the economy as a whole will not necessarily increase greatly over levels experienced in the 1970's. Currently, Social Security equals 4.8 percent of the GNP. Under intermediate assumptions—with 1.5 percent real wage growth—Social Security is expected to rise to 6 percent of the GNP by 2030, declining to 5.6 percent by 2060.

However, this relative increase in the number of beneficiaries will be a problem, despite productivity increases, if the Social Security tax base is allowed to erode. If current trends continue and nontaxable fringe benefits grow, less and less compensation will be subject to the Social Security payroll tax. In 1950, fringe benefits accounted for only 5 percent of total compensation, and FICA taxes were levied on 95 percent of compensation. By 1980, fringe benefits had grown to account for 16 percent of compensation. Continuation in this rate of growth in fringe benefits, as projected by the Social Security actuaries, will result in 2060 in nontaxable fringes accounting for 34 percent of compensation, leaving only 66 percent to be taxed for Social Security. This would be a substantial erosion of the Social Security tax base, and might undermine the long-term solvency of the system.

At this time, there are neither short- nor long-term deficits projected in the OASDI trust funds, and though there are a wide variety of issues that must be considered in the future, there is no compelling need for Congress to make major changes in Social Security in the near-term. However, it should be emphasized that Social Security is vulnerable to general economic conditions, and should they deteriorate, Congress may need revisit the financing of the system. Furthermore, Social Security may be subject to external political pressures to change its structure, notwithstanding its financial condition. Congress may well ignore the internal solvency of Social Security in the coming years and cut benefits in order to lower the Federal deficits.

(C) ADMINISTRATIVE ISSUES IN SOCIAL SECURITY

Over time, Congress has monitored the performance of the SSA in carrying out its most basic mission: dignified, high quality service to the public. In the 1950's and 1960's, SSA was viewed as an elite agency, marked by high employee morale, and excellent management. In the past 15 years, however, many have commented that the agency has lost its esprit de corps, and the quality of public service has declined. Factors cited as causing this decline have included: New agency responsibilities (for example, the creation of SSI in 1972) multiple administrative reorganization efforts; and the fact that in over the 12 years, there have been nine different Commissioners of Social Security. Many claim that public confidence in the agency is at an all time low, and that a mean-spiritness has marked the agency in the past few years.

(1) SSA as an Independent Agency

In the last two decades, many have argued that SSA's administrative performance would be improved if it were established as a separate agency, independent of the Department of Health and Human Services [HHS]. The National Commission on Social Security, reporting in 1981, recommended an independent agency, as did a majority of the members of the 1983 National Commission on Social Security Reform. Many have recommended that a bipartisan board manage and oversee Social Security, as was the case in the first decade of the program—1935–46. Advocates of an independent agency often cite the need for continuous, consistent leadership in Social Security, which is by nature a program involving very long-term considerations. It is frequently argued that Social Security, as an entitlement program, should be shielded from short-term partisan politics and bureaucratic infighting, and that administrative independence would enhance public confidence in the program.

The Congressional Panel on Social Security Organization was mandated by the Social Security Amendments of 1983 to identify an appropriate method for removing the SSA from HHS and establishing SSA as an independent agency, with its own administrative structure and responsibilities.

The panel's final recommendations to Congress include the following:

—An independent SSA should be headed by a single Administrator, appointed by the President, with the advice and consent of the Senate, to a statutory 4-year term.

—The agency would have responsibility for the OASDI and SSI Programs.

—A permanent, bipartisan Advisory Board of nine members—five appointed by the President, two by the Senate, and two by the House—would oversee the program, and would make policy recommendations to the Administrator, the President, and Congress.

—The new agency would be delegated certain administrative functions currently handled by the Office of Personnel Management [OPM] and the General Services Administration [GSA] to allow for greater operational flexibility.

Following the report of the Congressional Panel on Social Security Organization, a number of alternative proposals were introduced in the House and Senate. On June 20, Congressman Roybal introduced in the House [H.R. 5094], and Senator Pryor introduced in the Senate [S. 2778], legislation to establish SSA as an independent agency governed by a five-member, bipartisan Board. Under this proposal, five Board members would be appointed by the President for staggered 10-year terms. The Board would appoint a Commissioner to serve as the chief operating officer for a 5-year term. The Roybal-Pryor plan also creates an Inspector General's office, a public ombudsman, and a permanent Citizens' Advisory Committee. Like the Congressional Panel on Social Security Reform, the Roybal-Pryor legislation provides SSA with jurisdiction only over the OASDI and SSI Programs, and delegates to the agency authority presently handled by GSA and OPM.

On August 8, Senator Moynihan introduced legislation [S. 2922] similar to the Roybal-Pryor proposal. The major difference between the two is that the Moynihan bill incorporates Medicare within the administrative domain of SSA. In his floor statement, Moynihan contended that Medicare and Social Security are so closely allied in the public consciousness that they should be administered by one agency. He argued that it is important that the public receive information about both programs from a single office, to avoid unnecessary confusion. He further emphasized that including Medicare with Social Security would assure that it would receive the same status and priority as Social Security, with both strengthened under a unified independent agency.

Opponents of including Medicare in an independent SSA point out that it would be operationally advantageous to have an agency that handles cash benefits only, and that incorporating Medicare, which involves third-party intermediaries and a whole different set of administrative tasks, greatly complicates the mission of an independent SSA. Also, in the same sense that it is appropriate to link OASDI and SSI, it is reasonable to want to keep Medicare and Medicaid together, due to the overlap between the programs in clientele, structure, and purpose as public health care financing programs. If both Medicare and Medicaid were to be brought under SSA, it would leave HHS with little responsibility. Some argue that SSA would then be an enormously complex, multiprogram agency, with all the problems attendent upon HHS at present.

The various proposals to establish SSA as an independent agency raise a number of important policy issues. Most fundamentally, the question of whether it is necessary to remove SSA from HHS. Sponsors of independent agency proposals often point out that since 1971, SSA has had nine different Commissioners and HHS has had six different Secretaries. SSA has been administratively reorganized a number of times in the past decade, and there has been very little continuity or long-term coherence in leadership and policy. Further, advocates point to major policy debacles that have plagued Social Security in the past 5 years, including the crisis in the DI Program created by the overzealous implementation of the continuing disability reviews, and the retroactive elimination, and subsequent restoration of the minimum benefit. It is contended that with an independent agency, high level leadership would be more sensitive to the integrity of Social Security, and more effective in promoting sound policy and administration.

Opponents of an independent SSA point out that most agency problems do not result from SSA's location as a part of HHS, but are rather the result of poor planning and policymaking. Organizational structure may be less to blame than bad leadership, low morale, and ill-considered and voluminous congressional legislation. Some claim that changing an administrative structure will not by itself eliminate the problems of bad policy. This can only be accomplished by appointing intelligent and competent officials, and by Congress making legislative decisions less haphazardly and with greater consideration for the administrative ramifications of statutory changes.

Opponents of an independent agency also argue that an independent agency would not, and should not, put Social Security above politics. A Board appointed by the President would not necessarily be politically neutral, nor would a single administrator. In establishing an independent tribunal, with diminished accountability to the President, it is argued that Social Security will be less accountable to the views of the public, and less subject to reform or revision should that become desirable or necessary in the future.

(2) Recoupment of Overpayments

A very specific administrative concern in the recovery of benefit overpayments was revealed in a December 1983 Senate Aging Committee hearing on "Social Security: How Well is it Serving the Public?" Many recipients of Federal benefits elect to have their payments made directly to their bank account by an automatic credit process called electronic funds transfers [EFT]. In cases where these beneficiaries die, but continue to receive benefits, the Federal agency making the benefit payment notifies the Treasury Department that too much money has been credited to the account of the beneficary. The Treasury Department then seeks to recover payments for the month of death or thereafter by directing the bank where the beneficiary has an account to remove the amount owed to the Government from the account. This process takes place with no advance notice to the beneficiary or joint account holder, and is accomplished solely through the bank and the Treasury. In cases where the Federal agency has incorrectly recorded death information, improper recoveries have also been made with no prior notice to the beneficiary or to the surviving relatives. In 1983, there were over 300,000 Treasury recoupments involving the use of EFT procedures.

The beneficiary or joint account holder normally first becomes aware that money has been taken from his or her account only when it shows up in his bank statement or after other notification by the bank. Because the bank must quickly comply with the order to return the money to the Treasury Department, any notice provided by the bank usually occurs after the recoupment. This arrangement can result in cases in which the Treasury Department and the bank erroneously recover overpayments from EFT accounts without affording the beneficiary or account holder a chance to contest the overpayment claim or to seek a waiver of the recovery. It has caused much confusion and hardship to some Social Security beneficiaries.

At the close of the hearing, Senator Heinz asked Treasury Department officials to correct the problem by amending the Federal regulations dealing with overpayment collections from direct deposit bank accounts. In response, the Treasury Department issued new regulations, which became final on December 17, 1984.

The new regulations require the bank to notify beneficiaries that it intends to withdraw funds from their bank accounts to repay the debt to the Government. The notice procedure will cover recoupment of Social Security, black lung, SSI, and veterans benefits and civil service, railroad, and military retirement payments. The notice also informs the beneficiary that if he or she presents evidence to the bank that the fact of death or date of death is in error, the bank will correct the problem. Finally, it advises the account holder that he or she may be eligible for survivor's benefits and that the Federal agency making the payments should be contacted to determine eligibility for benefits.

It is believed that this simple notice procedure will help to avoid unfair surprise to the beneficiary when bank account savings are removed without his or her knowledge. Problems, such as check bouncing, that have resulted from this practice should also be reduced or eliminated. Finally, it satisfies the interest of the Government in collecting its debts and is acceptable to the banks which want to maintain good relations with their customers.

(D) BENEFITS

Social Security has an elaborate system of determining benefit levels for the 36 million Americans who receive them currently, and for all who will receive them in the future. Over time, this benefit structure has evolved, with Congress mandating changes as it felt necessary. Presently, there are a number of specific issues related to the benefit structure that have drawn the attention of Congress.

(1) The Social Security "Notch"

In 1984, interest continued in both the media and in Congress in the Social Security notch problem. Largely as a result of several columns by a nationally syndicated newspaper columnist, this issue has gained a great deal of public visibility, and did surface in the 1984 Presidential and congressional elections. The "notch" is a difference in monthly Social Security benefits between those born in 1916, and those born in 1917 or later, resulting from a change in the Social Security benefit formula enacted in the 1977 amendments. The differnce is substantial only for those in the highest benefit levels who defer retirement until age 65. This problem became noticeable as individuals born in 1917 became age 65 in 1982.

The problem stems from a series of changes the Congress made in the Social Security benefit formula, beginning over a decade ago. In 1972, the Congress enacted automatic annual indexing of both the formula to compute initial benefits at retirement, and of benefit amounts after retirement. The intent was to eliminate the need for ad hoc benefit increases, and to fix benefit levels in relation to economy. However, the method of indexing the formula had a flaw in it, in that, initial benefit levels were being indexed twice—for increases in both prices and wages. Consequently, initial benefit levels were rising rapidly in relation to the preretirement income of beneficiaries. Before the 1972 amendments took effect, Social Security replaced 38 percent of preretirement income for an average worker retiring at age 65. The error in the 1972 amendments caused replacement rates for the average worker retiring at age 65 to rise as high as 55 percent for the cohort born in 1916.

Without a change in the law, the average worker retiring around the turn of the century would have been receiving more in monthly Social Security benefits than he was earning prior to retirement.

This projected growth in relative benefits was the cause of the longrun deficit in 1977 estimated at 8.2 percent of taxable payroll. Had the Congress elected to finance this increase rather than reduce benefits, it would have had to double the Social Security tax rate. Instead, in the 1977 amendments the Congress chose to recoup part of the increase in relative benefits and finance the remaining benefit increase with a series of scheduled tax increases. Future benefits for the average worker under the new formula were set at 42 percent of preretirement income.

The intent of the 1977 legislation was to create a relatively smooth transition between those retiring under the old method and those retiring under the new method. Unfortunately, high rates of inflation in the late seventies and early eighties made the difference in monthly benefit levels between the cohorts born before and after 1917 greater than intended. The difference became most extreme for those who deferred retirement, particularly those with maximum earnings. For two maximum earners with identical earnings histories, one born in 1916 and the other in 1917, the difference in benefits for retirment at age 62 was only $7 a month. However these same individuals retiring at age 65 received benefits differing by $111 a month.

Although the notch is actually the result of an overindexation of benefits for those retiring under the old formula, and does not reflect any reduction in real benefits to those retiring under the transition rules, it has been perceived as a benefit reduction by those affected. Individual members of Congress have responded to the complaints of this group by introducing a series of proposals for relief, most of which would give benefit increases to notch-year retirees at a high cost to Social Security.

(2) Earnings Sharing

Social Security currently provides benefits to women in one of two ways: Either as a covered worker in her own right based upon her own earnings record or as a dependent wife, widow, or ex-wife of a covered worker. However, a woman cannot receive both benefits. Therefore, in the case of a one-earner couple, the Social Security benefit provided to a married couple is equal to one and one-half the benefit earned by the employed spouse. In the case of a two-earner couple, the Social Security benefit is based technically on their combined earnings record, but the lower earner's record is subsumed into the dependent spouse benefit, unless and until that record provides a larger benefit than the dependent spouse benefit.

This benefit structure was designed when less than 17 percent of married women worked outside of the home and the predominant family pattern was single-earner couples where the woman was the full-time homemaker and marriages were life long. Since mid-century, however, very different social patterns have emerged. The number of two-earner couples, for example, has risen dramatically, as has the number of marriages ending in divorce. Indeed, many of the presumptions upon which Social Security system was built have changed.

Three distinct groups of women may be considered disadvantaged by the current Social Security system. First, widows whose husbands die early have often been the recipients of reduced benefits for either of two reasons: (1) Their husband's incomplete earnings records yield low benefits, and (2) widows often take actuarially reduced benefits at younger ages.

Second, divorcees are entitled to dependent's benefits based on their last marriage—of 10 or more years duration—and are disadvantaged in two respects. The working ex-spouse may decide to retire early, without consulting his ex-wife and her benefits as a dependent spouse will be reduced. More importantly, if the marriage does not last 10 years, a divorcee is not entitled to a dependent spouse benefit at all. In the cases of women whose work histories have been interrupted by unsuccessful marriages, an insubstantial earnings record, and thus inadequate benefits are the inevitable result.

Finally, two-earner couples are disadvantaged by the current formula for determining benefits. A two-earner couple whose combined earnings equal those of a one-earner couple receive benefits substantially lower. This is due both to the additional dependent spouse benefit to the one-earner couple, as well as the fact that the base salary for determining the benefit of the two-earner couple will be the higher earner's salary—unless and until the lower earner is entitled, on the basis of her own earnings record, to a benefit larger than that which she would be entitled to as a dependent of the higher earner.

The earnings sharing proposal has emerged as the most popular of several comprehensive plans that would address these equity and adequacy issues. Under earnings sharing a couple's annual aggregate earnings would be divided equally between them for the purposes of computing a Social Security earnings record. This would effect three principle goals:

First, the individual would be entitled to a Social Security benefit in his or her own right, thus removing any stigma of dependency attached to that benefit—Some argue that the change would merely recognize the value of a woman's work in the home.

Second, it would allow divorced and widowed spouses to build on the earnings records amassed by their former spouses to improve their Social Security benefits.

Third, it would remedy the present inequities between one- and two-earner couples whose identical aggregate income yields unequal Social Security benefits.

Although no earnings sharing bill received serious consideration in the 98th Congress [H.R. 2739 was introduced by Representative Mary Rose Oakar; S. 3 by Senator Cranston]; this proposal has nonetheless been a subject of much discussion. The Social Security Amendments of 1983 required that the Social Security Administration study the costs and the benefits of the earnings sharing proposal. That study, due in July, was delayed until December so that analysts could complete a study of three alternative models of earnings sharing:

First, the no-loser proposal: Earnings sharing would be used to figure a participant's benefits, only if it afforded higher benefits than current law.

Second, strict earnings sharing: Benefits would be figured under earnings sharing as of a specified date regardless of the impact on the individual participant.

Third, moderated earnings sharing: The percentage of current law benefits guaranteed against earnings sharing would be gradually reduced over a period of 40 years when all participants' benefits would be figured by earnings sharing.

While earnings sharing would remedy the current inequities between one- and two-earner couples, preliminary analyses suggest that it is far less effective at improving the adequacy of benefits received by older widowed and divorced women. Since Social Security currently provides a spousal benefit to a divorced spouse after 10 years of marriage—so long as she does not remarry—Social Security benefits based only on the income earned during the marriage might be significantly lower, comparatively. Earnings sharing itself does nothing to remedy the problems of widows benefits under Social Security, except to encourage younger widows to add to the work record amassed by their spouses. To the extent that they do not, they will continue to receive inadequate benefits. While some earnings sharing proposals address this problem by guaranteeing at least current law benefits—the so-called no-loser bills—this adds tremendously to the implementation costs of earnings sharing. Other proposals include an inheritance of Social Security credits—upon the death of a spouse—to increase benefits for individuals living alone in old age.

It is likely that earnings sharing will receive more attention in the 99th Congress. However, policy concerns such as the implementation costs, adequacy of benefits to divorced and widowed elderly, as well as the political impracticality of modifying with Social Security so soon after the 1983 amendments will most likely retard the progress of the legislation.

2. LEGISLATION

Due to the strong financial condition of the OASDI funds engendered by the 1983 amendments, 1984 was a year marked by little legislative activity in Social Security. For the first time in a decade, insolvency was not pending, and Congress was able to avoid consideration of substantial tax or benefit changes.

However, one minor legislative issue did gain significant congressional attention. In the fall of 1984, it appeared as though the 1985 COLA might not be paid due to a little known provision put into the law in 1972. The Social Security Amendments of 1972 created an automatic mechanism to provide annual benefit increases based on the CPI. Yearly COLA increases were viewed as a means of insuring standard, predictable increases that did not require an ad hoc act of Congress to implement, and that did not exceed increases in the cost of living. One technical provision in the creation of annual COLA increases was a stipulation that in any year the CPI does not reach 3 percent, the COLA increase will be postponed a year. This provision was included in the law for administrative reasons—at the time, SSA's computer system was very primitive, and executing a COLA increase consumed a great deal of administrative resources.

During the late 1970's and early 1980's, the 3-percent threshold was always crossed, due to high inflation, and the COLA has never been postponed. However, in the summer of 1984, many analysts noted that the low level of inflation that had marked the end of 1983 and first two quarters of 1984 could have lead to a postponement of the January 1985 COLA. Since the COLA is announced at the end of October, days before the national elections, a COLA delay would have serious political repercussions. Recognizing this prospect, President Reagan announced in a press conference in the end of July that his administration would propose legislation to Congress to waive the 3-percent threshold for the 1985 COLA.

Before the administration submitted legislation, however, the Senate passed by a vote of 87 to 3 an amendment offered by Senator Moynihan on the Senate floor to a private relief bill. The Moynihan amendment waived the threshold for just 1985.

The House refused to accept without committee consideration the Senate amendment. Following this refusal the House Subcommittee on Social Security, of the Committee on Ways and Means, held a hearing on the COLA threshold issue on September 20. The committee then marked-up and reported to the full House H.R. 6299, a bill sponsored by Representative Rostenkowski, chairman of Ways and Means; and Representative Pickle, chairman of the Subcommittee on Social Security. H.R. 6299 waived the 1985 threshold, and mandated a study of the issue of eliminating the 3-percent trigger mechanism altogether. H.R. 6299 passed the House on October 2 by a vote of 417 to 4. It was accepted by a voice vote in the Senate on October 11, and the President signed H.R. 6299 into law on October 30 [Public Law 98-604].

Ultimately, the COLA threshold waiver proved unnecessary, due to a large jump in the CPI in the final months of the 1984 accounting period. Social Security and SSI beneficiaries are assured a 3.5 percent COLA in January 1985.

However, the threat of no COLA created an interest in permanently eliminating the COLA threshold. In the Senate, Senators Moynihan and Heinz introduced S. 2923 on August 8, legislation to remove the threshold from the law altogether. Similar legislation was introduced by Representative Conable in the House [H.R. 6019]. Advocates of permanent elimination argue that the threshold is antiquated due to administrative improvements by SSA—it is now much easier to compute and distribute COLA's, due to upgraded computer capacity. Eliminating the threshold would guarantee that COLA increases are distributed on a regular, predictable basis, which was the true intent of the 1972 amendments.

The major point of opposition to the permanent elimination of the threshold is that it might have a negative effect on the trust funds if a number of future COLA increases are awarded that otherwise would have been foregone. The potential effect is very hard to determine due to the difficulty of predicting future levels of inflation. Second, the equation is complicated by the fact that any COLA increase is accompanied by an increase in maximum wages taxable under Social Security, which generates additional revenue. Also, any COLA postponement involves a windfall to those who retire in the year the postponed COLA is distributed—this group receives a COLA compensating for the past 2 years of inflation, rather than for just the year in which they retire. The complex revenue and benefit effects of permanent elimination will be examined by SSA's Office of the Actuary next year, as a result of the COLA waiver threshold legislation.

B. SOCIAL SECURITY DISABILITY INSURANCE

In 1984, after 3 years of heated debate and controversy, Congress enacted the Social Security Disability Reform Act. This legislation revises the standards and the process used by the SSA in reviewing the eligibility of DI beneficiaries and applicants for DI benefits. The impetus behind this legislation was concern that SSA was mismanaging the DI Program, and that many people who deserved benefits were being denied them.

The Social Security Disability Amendments of 1980 mandated that SSA review the eligibility status of beneficiaries on the rolls at least once every 3 years, except those designated permanently disabled, who are reviewed once every 6 or 7 years. These periodic reviews are designed to remove from the rolls those beneficiaries who are no longer disabled, or never were disabled, and should not be receiving benefits.

Between March 1981 and April 1984, about 1.2 million case reviews were completed, and just under 500,000 beneficiaries were determined no longer eligible for DI benefits. In other words, 45 percent of those subject to a continuing disability investigation [CDI] were terminated from the DI rolls. This high termination rate, in conjunction with the fact that two-thirds of those who appealed to an administrative law judge [ALJ] had their benefits reinstated, led to concern that the CDI's were being administered in an improper and unjust manner.

Specifically, critics charged that the CDI's were being conducted hastily and haphazardly, and that the review simply did not render accurate or valid conclusions about a beneficiary's capacity to work. Though the problems with the disability review process are very complex and multifaceted, controversy centered on four key issues: (1) The extent to which persons can be terminated whose disabling condition has not improved, or even worsened, since their admittance to the rolls; (2) the manner in which medical evidence is obtained and evaluated; (3) the great discrepancy in standards of evaluation between State disability examiners, who initially conduct the CDI's and ALJ's; and (4) the degree to which the mentally disabled have been discriminated against by the CDI's.

The various problems with the continuing reviews were the focus of congressional hearings held by the House Ways and Means Committee, the House Select Committee on Aging, the Senate Committee on Finance, and the Senate Special Committee on Aging. Legislatively, the House and Senate passed differing versions of H.R. 3755 in the spring of 1984. By September, House and Senate conferees had negotiated an agreement, and final legislation was signed by the President on October 10, 1984 [Public Law 98-460].

Prior to congressional action, many States, on their own initiative or by court order, declared moratoria on the reviews, or began administering the CDI's under guidelines that differed from SSA's official policy. At the beginning of the year, more than half the

States were either not processing CDI's, or were doing so under modified standards. This unprecedented rejection of Federal policy is indicative of the magnitude of the crisis in the DI program created by the CDI's, and suggests that the restoration of order, fairness, and national uniformity to this progam will be an enormous challenge in the future.

1. ISSUES

(A) GROWTH AND CONTRACTION IN THE DI PROGRAM

From a conceptual standpoint, virtually all the complicated and esoteric aspects of the controversy in the DI Program boil down to one central question: how stringent—or lenient—do we want to be in the application of the DI Program? In Congress some argue that the DI Program is a runaway social welfare program, one that has grown far beyond the intentions of Congress, and that SSA's efforts to eliminate large numbers of people from the DI roles is justified. Critics of the CDI's in Congress claim that SSA has been overzealous, and that people who are clearly unable to work are being unfairly kicked off the rolls. Though the actual debate is very complicated, it centers around to one group calling for a very stringently administered program versus another group arguing for more lenient operation.

The definition of disability in the law is sufficiently broad, and the difficulty in making objective determinations is sufficiently great, that historically the DI Program has proven highly volitile, expanding and contracting in response to changes in administrative priorities and the intangible adjudicative climate that permeates decisionmaking.

(1) The Definition of Disability

When Congress created the DI Program in 1954, the definition it chose for "disability" was very strict. It was feared that anything other than a very restrictive definition would lead to: First, high costs; and second, confusion between disability—inability to *perform* work—and unemployment—inability to *find* work. The original definition required that to be eligible one had to be over age 50; insured under Social Security; and be unable to engage in any work by reason of a medical impairment which was expected to be permanent.

Over time the definition has been modified. In 1958, the coverage requirements were liberalized and dependents' benefits were made available. In 1960, the age 50 requirement was dropped. In 1965, the permanent disability standard was replaced by a more lenient definition: One had to have a disabling impairment expected to last at least 12 months or end in death. This brought under the program those who might recover and return to work, as well as to those who were expected to remain disabled until death. In 1967, Congress tightened the definition of disability, in response to Federal court decisions requiring SSA to demonstrate that employment was available that a denied applicant could reasonably find in his region of the country.

Since 1967, the basic definition of disability has remained essentially the same. An individual is not considered disabled unless his physical and mental impairments are of such severity that he is not only unable to perform in his previous occupation but cannot, considering his age, education, and work experience, engage in any kind of employment which exists in the national economy, regardless of whether such work exists in the region in which he lives, or whether a specific vacancy exists for him, or whether he would be hired if he applied. This is a very stringent definition, one that is meant to screen out those who cannot work because of a medically determinable impairment and those who cannot work for other reasons, such as obsolete skills, poor motivation, or job scarcity.

Though forceful as a general construct, this definition provides little specificity in determining disability in individual cases. To translate the broad statutory mandate into a workable administrative system, SSA has over the years developed an elaborate and immensely complicated scheme of regulations and rules to determine disability on a case-by-case basis. At the center of this system are a set of lists—the "listings of impairments"—of specific, medically identifiable impairments whose existence alone warrants a determination of disability. The "listings" are a way of codifying a large group of very severe medical conditions that are considered by definition disabling. This system allows a disability examiner to match a doctor's report against a set of uniform criteria, and make a clear-cut decision either way.

If an individual's impairment(s) do not "meet or equal" the listings, his "residual functional capacity" is assessed to determine whether he is nonetheless disabled. Unlike the listings, which are based on medical criteria, the evaluation of residual functional capacity is based on vocational factors. To accomplish this task, SSA has a complex "grid" system in which basic work skills are matched with such factors as age, level of education, and vocational experience to determine whether an individual can actually work. Vocational factors are given highest priority for applicants over the age of 55.

The very concrete and specific rules that underpin this two-stage evaluation process are spelled out in Federal regulations, and equally important, in the program operations manual system [POMS], an enormous body of internal administrative instructions and guidelines. The POMS are written by SSA, and sent to State disability determination service [DDS] agencies, which make the actual disability determinations under contract with SSA. The POMS and regulations are enforced through regional and national reviews of selected cases, and through clarifying internal memoranda. Overall, this elaborate system is structured to ensure to the greatest extent possible national uniformity and objectivity in determining disability.

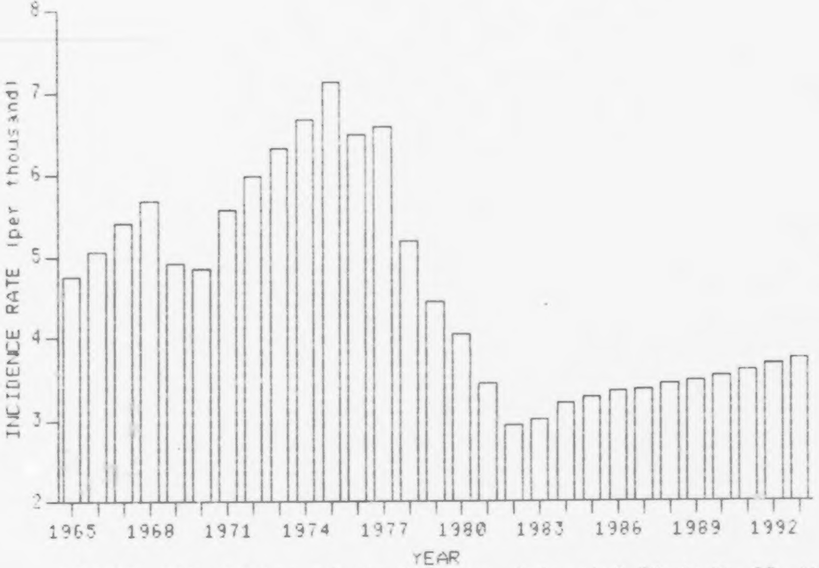
Though objective in design, the disability determination process remains highly subjective. Two doctor's can examine the same individual and reach different conclusions. Two disability examiners can read through the same medical evidence in a file and make differing decisions. Two individuals may have indentical impairments, but respond to them in radically different ways. There are a number of areas where medical taxonomy and understanding is weak or where an impairment is identified through indirect evidence. There are areas in which it is difficult to sort out the extent to which the individual is or is not responsible for the problem. Multiple impairments are very hard to consider in combination. Nonmedical factors are even more ambiguous. On the margins, which are very wide, the question arises, do you or do you not give the applicant the benefit of the doubt. In periods of program expansion, the answer tends toward yes, in contraction, no.

(2) The Disability Incidence Rate

Over time, one key indicator of the generosity or stringency of the DI Program is the "disability incidence rate," a measure of the number of workers awarded DI beneficiares in any year as a fraction of the total number of workers insured for DI benefits. Throughout the 1960's, the disability incidence rate was fairly constant, particulary when legislative changes are taken into account. However, beginning in 1970, the disability incidence rate increased by almost 10 percent a year until 1975 when it reached its peak. After 1975, the rate started to decline. This decline became precipitous following 1979. It dropped to a historic low in 1982, during the period of most intensive retrenchment. Social Security actuaries currently project the disability incidence rate will remain low, though ascend modestly for the next decade.

CHART 4

DISABILITY INCIDENCE RATES
1965-1993



SOURCE: SSA, Office of the Actuary, Actuarial Study No. 93, Nov. 1984
Note: Data for years 1981-83 are preliminary, 1984-93 are projections

(a) The expansionary period

Growth in the early and middle 1970's had an enormous effect on the size and cost of the DI Program. Between 1970 and 1976, the number of disabled workers almost doubled, while the covered work force increased by only 25 percent. In 1970, annual expenditures under the DI Program were $3.3 billion; in 1980, they amounted to $15.9 billion.

What explains this growth? A number of factors are usually cited in describing the expansion of the DI Program. First and foremost is lenient Federal management. The establishment of the Black Lung Program in 1970, and the creation of the Supplemental Security Income [SSI] Program in 1974 severely constrained SSA's administrative resources. Simultaneous with the additional responsibilities associated with black lung and SSI, DI applications increased from 868,000 in 1970 to 1.3 million in 1974. To process these claims, SSA established a number of expedients in the area of development, documentation, and review of claims. For instance, SSA eliminated its 100 percent review of State DDS cases and instead only sampled a small percentage of decisions. The net result of this pressure to process claims may have been a tendency to give the applicant the benefit of the doubt in "gray area" cases.

Another important factor is the social acceptance of disability. Though medical evidence points to no increase in impairments, workers of all ages in the 1970's increasingly claimed that they were disabled.

TABLE 2.—SELF-REPORTED INABILITY TO PERFORM USUAL MAJOR ACTIVITY AMONG MEN, AGE 45 TO 64

[In percent]

	Did not complete high school	High school graduate	More than high school
Year:			
1969	10.6	4.0	2.8
1974	15.1	5.4	3.5
1978	17.1	7.4	3.9

Source: National Center for Health Statistics.

Disability is both a medical and a social concept. To the extent that workers become more and more willing to claim that they were disabled, and to the extent political and administrative conditions allowed for program expansion, large numbers of people became eligible for DI benefits.

Others factors fueling the growth of the DI Program include: First, greater public awareness of the availability of benefits, due to the creation of SSI; second, higher benefit levels due to across the board Social Security increases mandated by Congress; and third, high unemployment throughout the 1970's, particularly 1974 and 1975.

(b) Program contraction

Beginning in 1978, a major contraction in the DI Program began. The disability incidence rate was halved between 1977 and 1982.

Despite inflation, DI benefit costs have remained fairly constant between 1981 and 1984, hovering about $17 billion. The total number of DI beneficiaries has decreased from a historic high of 4.9 million in 1978 to 3.8 million in 1984.

Why this retrenchment? Most significantly, the "adjudicative climate" in the DI Program changed drastically. Prodded by criticism by GAO and Congress, SSA made a number of administrative changes to make more strict the eligibility and review process. SSA began reviewing more State agency cases, and returning them to clarify SSA's interpretation of the law. SSA began to crackdown on interstate variation in eligibility standards, and implemented a number of regulatory and administrative procedures to assure more centralized control over the program. Overall, disciplinary pressures were created to minimize the flexibility of State agency examiners in "gray area" cases. Administrative standards were promulgated that reflected a strict, conservative interpretation of the law.

Contraction was also engendered by congressional legislation. In response to the growth of the DI Program in the early and middle 1970's, Congress enacted the legislation in 1977 and 1980 to increase revenues and control expenditures. In the 1977, Congress substantially increased payroll taxes, and revised the method of indexing benefits. This legislation decreased future benefits, and may have made DI less financially attractive to potential applicants.

The Social Security Disability Amendments of 1980 were broader in scope, and are the explicit source of the current controversy in the DI Program. The 1980 amendments had been developing since 1974, and were a product of concern that work disincentives, in combination with loose administration and large benefits, were responsible for the growth in the program. The 1980 amendments required SSA to more systematically review State agency performance, as well as that of ALJ's, who are often cited as a liberalizing element in the disability determination system. The legislation put a limit on maximum family benefits to ensure that beneficiaries would not receive benefits in excess of pre-disability earnings. It also included a number of provisions to lessen work disincentives in the program.

The provision in the package that has had the biggest impact on the program is the requirement that SSA review the continuing eligibility of beneficiaries at least once every 3 years, except for the permanently disabled. Though not understood as a major change in 1980, it is this requirement that has underpinned the most controversial aspect of contraction: The continuing disability reviews and massive disentitlement to benefits.

(B) THE CONTINUING DISABILITY INVESTIGATIONS (CDI'S)

Since the inception of the DI Program, SSA had the responsibility of continuously monitoring the eligibility of beneficiaries on the rolls. In response to the concern that SSA was not reviewing eligibility carefully enough, Congress included in the 1980 amendments a provision that SSA review eligibility at least once every 3 years.

It should be noted that this periodic review provision was not expected to yield significant savings until 1984. The CDI's were intended to begin on January 1, 1982, with their implementation producing a net savings of only $10 billion in the 4-year period between 1982 and 1985.

A GAO report issued in January 1981 estimated that as many as 20 percent, or 584,000, of the beneficiaries on the DI rolls were either ineligible or receiving too large a benefit payment. The report claimed that SSA's management of the DI Program was deficient, and in particular, that SSA's procedures for reviewing the disability status of individuals who were likely to have improved were seriously flawed. Most individuals never had their eligibility reviewed; and of those that met the criteria for reexamination, most were never actually rereviewed. GAO recommended that SSA make more strict the administration of the program, and expedite the CDI's.

On its own initiative, SSA accelerated the implementation of the reviews scheduled to begin January 1, 1982, to March 1981. SSA witnesses at congressional hearings repeatedly cited the GAO report, and congressional pressure—as witnessed in the 1980 amendments—as justification for this acceleration. However, this decision was strongly influenced, if not determined, by Office of Management and Budget directives to produce additional savings in the DI program.

The accelerated reviews were included as part of the Reagan administration's fiscal year 1982 budget initiatives, and involving reviewing 30,000 additional DI cases per month beyond the regular review workload. In fiscal year 1980, SSA reviewed the continuing eligibility of of 160,000 beneficiaries; in fiscal year 1981, close to 260,000 CDI's were conducted. Once initiated, the volume of the CDI's increased dramatically. Overall, between March 1981 and April 1984, 1.2 million case reviews were completed, and 485,000 beneficiaries were determined no longer eligible for DI benefits.

TABLE 3: CONTINUING DISABILITY INVESTIGATIONS SUMMARY DATA, 1981-84 1/

Fiscal year	Initial State Agency Decisions				Reconsiderations			Hearings			
	Total 2/ cases reviewed	Total decisions made	Continu- ances	Termina- tions	Total decisions made	Continu- ances	Termina- tions	Total decisions made	Continu- ances	Termina- tions	Dismis- sals
1981........	180,000	146,000	76,000 (51.8%)	70,000 (48.2%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
								(Available 2/82-9/82)			
1982........	497,000	435,000	240,000 (55.1%)	195,000 (44.9%)	96,000	12,000 (12.7%)	84,000 (87.3%)	41,000	25,000 (61.3%)	13,000 (31%)	3,000 (7.7%)
1983........	544,000	466,000	273,000 (58.6%)	193,000 (41.4%)	154,000	26,000 (17.0%)	128,000 (83.0%)	111,000	67,000 (60.7%)	35,000 (31.4%)	9,000 (7.9%)
1984..3/.... (10/83-3/84)	132,000	109,000	82,000 (75.1%)	27,000 (24.9%)	29,000	8,000 (27.3%)	21,000 (72.7%)	62,000	40,000 (65.3%)	18,000 (28.9%)	4,000 (5.8%)

1/ Includes title I, title XVI, and titles II/XVI concurrent cases and includes medical diary cases as well as periodic review cases. Figures rounded to nearest thousand but percentages based on actual figures. The data relate to workloads processed at the various levels for the given time period, but the reconsideration and hearings requests processed in a given period will include some cases where the initial decision was made in a prior period.

2/ Includes no decision cases--cases where the State agency makes no decision for various reasons, e.g., death of the beneficiary, transfer of jurisdiction to another State agency, return of case to SSA district office for further development or because beneficiary is working.

3/ Includes some preliminary data.

Source: Social Security Administration, December 1984.

Not long after the CDI's were implemented in March 1981, congressional concern arose about the quality, accuracy, and fairness of the reviews. Press accounts of severely disabled individuals who had been terminated from the rolls began to proliferate; and constituent reports to Members of Congress began to establish an alarming pattern of questionable terminations. It became clear that close to half of all DI beneficiaries subjected to a CDI were terminated at the initial decision level, often without much warning, and in many instances without much evidence that the individual was not disabled. Significantly, about two-thirds of those terminated had their benefits reinstated, if they appealed to an ALJ.

Overall, congressional interest in the controversy associated with the CDI's has centered on a few key issues, discussed below.

(1) Medical Improvement

One of the first problems cited with the CDI's was the fact that beneficiaries were being terminated from the rolls despite the fact that their disabling condition had not improved, or had worsened. In essence, beneficiaries admitted to the rolls under one set of standards were being reevaluated upon a new, more stringent set of standards, and many were being terminated. People who had been placed on the DI rolls 5, 10, and 15 years before the CDI's, many of whom had been led to believe they had been granted a lifetime disability pension, were removed from the rolls with little advance warning or explanation.

The central issue in the debate surrounding the concept of medical improvement is the question of who must bear the burden of proof in the determination of continuing eligibility for DI benefits. Under SSA's interpretation of the law, it was the obligation of the beneficiary to prove during the course of a CDI that his or her disability meets contemporary eligibility criteria. How long that person has been on the rolls, or whether or not that person is physically or mentally more fit for employment than when first granted disability status, is immaterial. SSA is obligated only to evaluate cases in relation to present day medical and vocational standards.

With a medical improvement standard, the burden of proof shifts from the beneficiary to SSA, and it becomes the obligation of the agency to demonstrate that the individual's disabling condition has improved. In essence, entitlement to DI benefits creates a presumption of continuing eligibility until the Government can demonstrate that there is a reason why benefits can be denied.

In the historical context of leniency and expansion in the early and mid-1970's, and stringency and contraction in the early 1980's, medical improvement becomes a vital question. To terminate someone entitled to benefits 10 years ago simply because administrative standards have changed strikes advocates of a medical improvement standard as unfair. However, to grandfather on the rolls someone who would not be allowed on the program under current standards is seen as creating a double standard that discriminates against new applicants, in the view of opponents of medical improvement.

Medical improvement has proven to be a very important issue in the courts. A number of Federal courts have ruled that SSA's policy of only evaluating one's condition in relation to current administrative standards is in violation of the law, and that SSA must demonstrate that an individual has improved medically while on the rolls, or that the original decision was clearly erroneous before terminating benefits. Other courts have ruled that once a person has been found disabled, there is a presumption that the individual remains disabled and that SSA bears the burden of proof in determining that beneficiary is no longer disabled.

The Ninth Circuit Court of Appeals has ruled in two cases— *Finnegan* v. *Mathews* and *Patti* v. *Schweiker* that SSA must incorporate a medical improvement standard into its administration of the CDI's. Courts in virtually every other circuit have since rendered medical improvement decisions unfavorable to SSA.

(2) Uniform Standards

One of the critical problems in the disability review process is that different levels of review are bound to different evaluational criteria. The fact that ALJ's reverse almost two-thirds of all appeals of state agency termination decisions is the most striking indication of this structural situation.

This lack of administrative uniformity has been exacerbated in the past few years through SSA's policy issuing substantive policy changes through subregulatory means, such as the POMS' internal memoranda, and Social Security rulings. These changes are not open to public comment and review. To the extent that there are ambiguities or substantive conflicts between these subregulatory standards and published Federal regulations, State disability examiners are bound to SSA administrative directives, while ALJ's adjudicate on the basis of formal regulations.

The root of this inconsistency lies in the statuatory exclusion of SSA from the rulemaking requirements defined in the Administrative Procedures Act [APA] of 1946. The APA requires that if an agency intends to propose rulemaking changes, it must publish those proposals in the Federal Register and allow for public comment and review. Agencies are allowed to use internal subregulatory channels to disseminate instructions that serve to clarify or provide interpretive assistance in the concrete administration of the rules. Though HHS has voluntarily agreed to follow APA guidelines, SSA nonetheless continues to promulgate sustantive policy changes through subregulatory methods without ever allowing for public inspection.

The upshot of this practice is that there is no uniformity throughout the disability review and appeals process. State examiners are bound to a very strict interpretation of the law, and are very sensitive to SSA's internal administrative pressure and discipline. ALJ's, on the other hand, have more flexibility and independence in interpreting Federal regulations. Because of this freedom, ALJ's have acted as a break on administrative retrenchment.

(3) Mental Impairments

One of the most heavily criticized aspects of the CDI's is that the reviews have been especially harsh for mentally disabled beneficiaries. Evidence presented at a Senate Special Committee on Aging hearing in April 1983 demonstrated that the mentally impaired were among the most likely to be reviewed, and the most likely to be terminated, of the beneficiary population.

The determination of disability for the mentally impaired has proven to be particularly susceptible to swings in the adjudicative climate, due to the inherent difficulty of medically documenting mental disorders. Many mental impairments are diagnosed through indirect, symptomological evidence, and it often hard to establish through scientific methods the precise nature and degree of the disorder. Further, the disability determination system is very much oriented toward drawing a sharp distinction between voluntary and involuntary sources of disability, so that only those who are afflicted by a catastrophic, medical condition are awarded benefits, and those who simply many not want work are excluded from benefits. With mental impairments, it is not always easy to draw clear distinctions between the whether one is or is not responsible for the problems, or that one can or cannot control them.

In the early and mid-1970's, large numbers of mentally impaired people were put on the rolls, particularly through SSI. Following the deinstitutionalization of hundreds of thousands of the mentally ill from State hospitals, SSI and DI became major sources of support. With a favorable period of administrative leniency, the benefit of the doubt was frequently given to the mentally impaired, and thousands became entitled to benefits.

When the CDI's began, the mentally disabled were among the hardest hit. At the Senate Aging Committee hearing, GAO reported that although only 11 percent of those on the DI rolls are there because of mental impairments, 27 percent of those terminated by the CDI's were of the mentally disabled category. Further, ALJ reversal rates for mental disability appeals cases were much higher—91 percent—proportionally than for the rest of the disabled population.

In a period of contraction, those with mental impairments were particularly vulnerable. SSA sent a message to the State agencies to rigidly enforce the listings for mental impairments, which are very strict, and antiquated, in the view of critics, and to be very narrow in evaluating residual functional capacity. With this tightening of standards, and with the administrative constraints caused by the sheer volume of reviews, State agencies were pressured to disentitle tens of thousands of mentally impaired beneficiaries.

In two important class action suits, *Mental Health Association of Minnesota* v. *Schweiker* and *City of New York* v. *Heckler,* SSA has been found guilty of implementing a covert and illegal policy that systematically discriminated against the mentally ill. Both courts ruled SSA must reopen the cases of all mentally impaired individuals initially denied or terminated from the disability rolls, and reexamine their eligibility under lawful guidelines.

The essense of this illegal policy consisted of SSA internal memoranda, returns and reviews to State disability determination offices requiring that if an individual does not meet or equal the listing of impairments, that person can be presumed to be capable of performing unskilled work. That policy resulted in a virtual automatic denial of benefits to mentally impaired claimants under age 50.

In New York, District Judge Jack B. Weinstein argued that "the result of SSA's surreptitious undermining of the law was particularly tragic in the instant case because of its devastating effects on thousands of mentally ill persons whose very disability prevented them from effectively confronting the system." He also noted that by denying disability benefits to the mentally impaired, SSA simply transferred the costs of their care to the social service agencies, hospitals, and shelters of New York City and New York State.

Both courts found that SSA was not conducting the fourth step of the sequential evaluation—the evaluation of residual functional capacity—in accordance with the law. "The assessment of RFC, if it was done at all was reduced to a paper charade in which any individual who did not meet or equal the listings was assumed, ipso facto, to be capable of unskilled work." Judge Weinstein summarized the implications of this policy in the following passage:

> The Social Security Act and its regulations require the Secretary to make a realistic, individual assessment of each claimant's ability to engage in substantial gainful activity. The class plaintiffs did not receive that assessment. On the contrary, SSA relied on bureaucratic instructions rather than individual assessments and overruled the medical opinions of its own consulting physicians that many of those whose claims they were instructed to deny could not, in fact, work. Physicians were pressured to reach conclusions contrary to their own professional beliefs in cases where they felt, at the very least, that additional evidence needed to be gathered in the form of a realistic work assessment. The resulting supremacy of bureaucracy over professional medical judgments and the flaunting of published, objective standards is contrary to the spirit and letter of the Social Security Act.

(4) Quality of the CDI's

Not long after the CDI's were first implemented, it became clear that there were serious inadequacies in the review process. Without sufficient time, staffing, or resources, State agencies were forced to process far too many CDI's, far too quickly. Further, the manner in which the cases were developed, including the collection of medical evidence, came into serious question.

The simple increase in volume from a routine 160,000 reviews per year to roughly 500,000 CDI's in fiscal year 1983, in and of itself accounts for a major dimension of this problem. The phase-in period was much rapid than intended by Congress, and State agencies sacrificed thoroughness and accuracy to speed and efficiency. Like in the mid-1970's, case examiners found themselves under severe pressure to process claims quickly. In this instance, however, the signal from SSA was to deny claims whenever possible.

Another problem cited with the CDI's was their impersonal, paper-oriented character. CDI's were conducted without the benefit of any face-to-face interaction betweeen the beneficiary and the disability examiners. Before the ALJ stage, determinations were based strictly on written evidence. Further, beneficiaries were often provided with little information as to what a CDI entails, what was expected of them, and what the range of potential outcomes from the CDI might be.

(5) Multiple Impairments

Another issue of interest to Congress is the role the combined effect of multiple impairments should play in the disability determination process. Under SSA's administrative practice, if an individual had several impairments, none of which on their own constitute a severe impairment, that individual was disqualified at the first level in the sequential evaluation, the test of a severe or nonsevere impairment. There was no determination of whether vocational factors might be disabling, or whether nonsevere impairment might cumulatively render an individual unable to work.

SSA reasoned that if an impariment does not substantially limit an individual's ability to work, the individual was not disabled, and there was no point in continuing the sequential evaluation. Further, it was assumed that a combination of nonsevere impairment would not seriously restrict ability to work. In view of the structure of the eligibility determination process, SSA categorically denied eligibility when the first test of disability—is there a severe impairment?—failed. In the past few years, rejection of claims on the basis of not having a severe impairment increased dramatically, and closing this point of entry into the review system has led to many denials.

Critics argued that SSA was violating the meaning of the law in denying a claimant a realistic, individualized assessment of work ability by not evaluating impairments in combination and not examining vocational factors. SSA's categories served to exclude people who, if evaluated in totality, were disabled. Like mental impairments, the combined effects of multiple impairment are difficult to identify medically, and involve what is ultimately subjective judgment. SSA has done as much as possible to limit the flexibility of State examiners in areas where subjectivity is most prevalent, and in this fashion has directed them to deny gray area cases.

(6) Pain

As a medical phenomenon, pain is very poorly understood, and has served as an area of contention in the DI Program. Until recently, the statute was silent on how it was to be treated in the disability determination system. SSA relied on regulations drafted in 1980 that stated that pain is a symptom, not an impairment, and that its existence alone cannot be used as evidence of disability. There must be medical documentation that shows there is a medical condition that could be reasonably expected to produce the pain. As such, objective or subjective evidence of pain is only considered insofar as SSA has identified a cause of that pain.

A number of courts have ruled that this policy is not in conformity with the law, in that pain may be disabling to an individual, regardless of whether its genesis is understood. Severe pain may serve to limit one's ability to perform basic work functions. By not considering pain as a potentially disabling impairment, SSA is not realistically evaluating whether one can or cannot work.

(7) State Actions

A great number of States have revolted against SSA's recent practices and policies relating to the CDI's, and many Governors and State agency administrators have imposed moratoria on the reviews. On March 8, 1983, Massachusetts Governor Dukakis issued an executive order requiring the State disability determination office to implement a medical improvement standard in reviewing cases, as ordered by a district judge in *Miranda* v. *Secretary of HHS*. Arkansas, Kansas, and West Virginia similarly implemented review procedures at odds with official SSA policy. In Kansas, Governor Carlin also ordered that the reopening and reexamination of all cases terminated since March 1981.

On July 22, 1983, Cesar Perales, commissioner of the New York State Department of Social Services, suspended reviews pending the establishment of a medical improvement standard. Alabama, New Jersey, Pennsylvania, Michigan, Maine, Illinois, Virginia, North Carolina, Ohio, and New Mexico all initiated moratoria on the reviews. Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon, and Washington also initiated temporary or indefinite moratoria. Combined, more than half the States, at the beginning of 1984 were either not processing the reviews, or were conducting them under standards that varied with official SSA procedures and requirements.

This rebellion of the States has been cited by advocates of reforms as an indication of just how completely the DI Program disintegrated, and how urgent was the need for comprehensive reform. Opponents of comprehensive legislation viewed this development as a product of the fact the States have no real financial stake in DI benefits, which are paid for in total by Federal funds, and that perhaps federalization of the disability determination is in order.

2. LEGISLATION

(A) SOCIAL SECURITY DISABILITY REFORM ACT OF 1984

In 1982, 1983, and 1984 a great number of legislative proposals were introduced to address various problems in the CDI's. In late 1982, Congress passed as an amendment to a Virgin Islands tax bill certain limited measures to slow the volume of the CDI's, and improve the mechanics of the review process [Public Law 97-455]. Two comprehensive bills introduced in 1983, H.R. 3755 and S. 476, were enacted this year as the Social Security Disability Benefits Reform Act of 1984. Throughout the entire period, dozens of congressional hearings were held, and the DI Program was a subject of continuing debate and controversy.

In 1984, attention was focused on passing comprehensive reform legislation. In the summer of 1983, the Subcommittee on Social Security of the House Ways and Means Committee marked up H.R. 3755, legislation introduced by the subcommittee's chairman, J.J. Pickle. The full Ways and Means Committee subsequently folded H.R. 3755 into a larger legislative package, H.R. 4170, which included changes in the Tax Code, Medicare, Medicaid, and other programs. It was the intention of the committee for the House to act on H.R. 4170 in the fall of 1983, but controversy over certain tax provisions blocked House consideration.

When Congress reconvened in 1984, the House leadership decided to split the disability provisions out of H.R. 4170, and consider the legislation independently. On March 14, 1984, the Ways and Means Committee reported to the full House H.R. 3755 on its own. The House passed H.R. 3755 on March 27, by an overwhelming vote of 410 to 1.

In the Senate, Senators Cohen, Levin, and Heinz introduced S. 476 on February 15, 1983. In many respects similar to H.R. 3755, S. 476 was composed of a comprehensive package of measures to reform the DI Program. Though the Senate Finance Committee did not act upon S. 476 in 1983, the full Senate did consider a scaled-down version of the bill on November 17, 1983, when Senator Levin offered it as an amendment to H.R. 3959, a supplemental appropriations bill. The amendment was tabled by a vote of 49 to 46. This defeat was a product of a number of factors, including the opposition many Senators hold to offering substantive authorizing legislation to appropriations bills, the fact that the Finance Committee had not recommended the bill, and the strong opposition of the Reagan administration to the amendment.

On January 25, 1984, the Finance Committee held a hearing on the DI Program. The key witness was Martha McSteen, Commissioner of Social Security, who conveyed the administration's opposition to H.R. 3755 and S. 476, and urged that the problems in the review process could be handled administratively. Though many advocates and experts testified on behalf of comprehensive reform, the opposition of the administration to the legislation led Senator Dole, chairman of the Finance Committee, to stall consideration of S. 476.

In order to develop a sense of how the CDI's were impacting disabled people throughout America, the Senate Aging Committee, the Senate Budget Committee, and the House Ways and Means Committee held field hearings across the country in the spring of 1984. On February 16, 1984, the Senate Aging Committee held a field hearing in Chicago. In this hearing, and in one held the next day jointly with the House Subcommittee on Social Security in Dallas, consensus was demonstrated for the need for reform. Disability beneficiaries graphically described the human effects of the CDI's. Experts, advocates, and disability examiners all called for a revamping of the program. Representatives of the States argued that SSA's standards were unfair and did not render accurate decisions on disability. All testified to the merits of medical improvement.

Under an immense amount of pressure from Congress, the States, the courts, and the media, the administration withdrew its opposition to reform legislation. On April 13, 1984, 2 weeks after House passage of H.R. 3755, Secretary of Health and Human Services Heckler ordered a moratorium on all CDI's until legislation had been enacted and implemented. This action was viewed as a statement that the administration found it politically untenable to continue to oppose legislation, and a desire to shape the final legislative package through influence in the Senate.

On May 17 and 18, after a number of failed attempts earlier in the month, the Senate Finance Committee marked up S. 476, and reported the bill to the full Senate. On May 22, the Senate passed S. 476 by a vote of 96 to 0—for procedural purposes, S. 476 was passed as the Senate's version of H.R. 3755.

The House and Senate's versions of H.R. 3755 differed substantially, with the House bill generally more expansive, and the Senate version more conservative. The Senate bill had a medical improvement standard, but it was less favorable to the beneficiary than the House version, and was to applied to a much smaller group. The Senate bill also included a controversial fail-safe financing mechanism attached by Senator Long, ranking minority member of the Finance Committee. Overall, the Senate bill was less expensive than the House bill, and made fewer changes to the basic review process.

Throughout the summer of 1984, House and Senate conferees could not come to an agreement on a compromise package. House conferees opposed passing legislation without fundamental safeguards for beneficiary rights, while Senate managers wanted to ensure that the legislation would not open the gates of the program for a period of uncontrolled expansion. Generally, House conferees were bargaining for a more lenient package; the Senate position was for a more stringent one. Finally, in mid-September a conference agreement was reached. The final package passed both Houses unanimously on September 19, 1984. The President signed the bill on October 9.

(B) KEY PROVISIONS OF THE ACT

The following provides a summary of the major provisions in Public Law 98-460.

(1) Medical improvement standard.—A beneficiary's eligibility may be terminated only if there is substantial evidence that his or her medical condition has improved and he or she is judged to be capable of working under current standards. If there has been no medical improvement over time, SSA can still terminate benefits if one of the following exceptions applies:

(a) The individual has benefited from advances in medical or vocational therapy or technology, and is now able to work.

(b) The beneficiary's impairment is now considered less disabling than thought before, due to advances in diagnostic techniques or evaluations, and is now able to work.

(c) The prior determination was erroneous.

(d) The original decision was fraudulently obtained, or the individual is working, cannot be located, or has failed to follow prescribed treatment which could be expected to enable him to work.

The determination will be based on all the evidence in the case file, including new information supplied by the individual or secured by SSA. The decision must be rendered on the weight of the evidence with neither the beneficiary nor the Government bearing the burden of proving or disproving medical improvement.

The new medical improvement standard is intended by Congress to apply to the following groups of people:

(a) All new CDI cases and cases upon which an administrative appeal is pending.

(b) Cases of individual plaintiffs and named litigants in class actions suits pending in Federal courts on September 19, 1984.

(c) Cases of unnamed members of class action suits certified before September 19, 1984; and

(d) Cases in which a person filed for judicial review of a final administrative decision within 60 days prior to enactment.

Cases pending in Federal court are to be sent back to SSA for review under the medical improvement standard. Unnamed litigants in certified class-action suits will be notified by mail that they have 120 days after receipt of the notice to request a review of their case under the new standard. Cases in the administrative appeals pipeline will have their cases automatically re-reviewed.

Individuals whose cases are sent back or who request a review under the new standard are entitled to elect to receive benefits pending the new decision. If found eligible, the individual will receive retroactive benefits to the date he or she was found ineligible.

One important aspect of the application scheme is that courts are precluded from certifying class action suits related to medical improvement after September 19, 1984. It was the intention of the conferees to limit the application of this standard to all those who had either appealed on their own in a timely fashion, or who had reason to expect further action on their case due to inclusion in a certified class action suit.

(2) Pain.—The bill incorporates SSA's regulatory standard into the law. A person's subjective statements alone shall not be conclusive of disability. There must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities which could reasonably be expected to produce the pain. This evidence is to be considered along with statements of the individual or his physician as to the intensity or persistence of such pain or other symptoms which may reasonably be accepted as consistent with the medical signs and findings. The new pain standard expires on January 1, 1987.

The Secretary of HHS shall appoint a Commission on the Evaluation of Pain to conduct a study, in consultation with the National Academy of Sciences, the use of subjective and objective evidence of pain in determining disability, and of the state of the art of preventing, reducing, or coping with pain by December 31, 1985.

(3) Multiple impairments.—Provides that in determining whether a person's condition is of a sufficient medical severity for disability benefits, the SSA must consider the combined effect of all of the person's impairments whether or not any one of them would alone be severe enough to qualify the person for benefits. The provision applies to all determinations made on or after 30 days after enactment.

(4) Moratorium on mental impairment reviews.—Provides for a moratorium on reviews of all cases involving a disabling mental impairment until the mental impairment criteria are revised to realistically evaluate the person's ability to perform work in a competitive workplace environment. The moratorium applies to all

cases in which an administrative or judicial appeal was pending on or after June 7, 1983. All persons claiming benefits based on a disabling mental impairment who received an unfavorable initial or continuing disability decision after March 1, 1981, could reapply for benefits within 12 months of enactment.

(5) Pretermination notices.—Requires the Secretary to initiate demonstration projects on providing face-to-face interviews for pretermination continuing disability cases and all initial denial cases, in lieu of face-to-face evidentiary hearings at the reconsideration stage of appeal. The projects are to be conducted in at least five States with a report due to the Committees on Ways and Mean and on Finance by April 1, 1986. Also requires SSA to notify persons upon initiating a periodic eligibility review that termination of benefits could be the result of the review, and that additional medical evidence may be submitted for consideration.

(6) Continuation of benefits during appeal.—Provides for continuation of benefits during appeal for all continuing disability review cases through the hearing stage of appeal, at the election of the individual. Where the administrative law judge's decision is adverse to the person, these benefits would have to be repaid. The provision is permanent for SSI disability recipients, but applies to disability insurance beneficiaries only through December 1987. SSA is required to report to Congress on the impact of this provision by July 1, 1986.

(7) Qualifications of medical professionals.—Requires the Secretary to make every reasonable effort in cases based on mental impairments to insure that a qualified psychiatrist or psychologist completes a review of the case before any determination may be made that a person is not disabled.

(8) Standards for consultative examination/medical evidence.—Requires SSA to promulgate regulations regarding consultative medical examinations, including when they should be obtained, the type of referral to be made, and the procedures for monitoring the referral process. SSA must make every effort to obtain necessary medical evidence from the treating physician before evaluating medical evidence from any other source. SSA must also consider all evidences in the case record and develop a complete medical history over at least the preceding 12-month period.

(9) Administrative procedure and uniform standards.—Requires publication of regulations setting forth uniform standards for DI and SSI disability determinations under section 553 of the Administrative Procedures Act, to be binding at all levels of adjudication.

(10) Nonacquiescence.—No statutory provision is included in the conference agreement. The conference report states that the agreement to drop both the House and Senate provisions is not to be interpreted as approval of the practice of nonacquiescence with circuit court decisions by the administration. The conferees note that questions have been raised about the constitutional basis of the practice, that many of the conferees have strong concerns about the current practice, and that a policy of nonacquiescence should be followed only where steps have been taken or are intended to be taken to receive a review of the disputed issue in the Supreme Court. The conferees also urge SSA to seek a resolution of the nonacquiescence issue in the Supreme Court.

(11) Payment of Costs of Rehabilitation Services.—Allows reimbursement to State agencies for costs of rehabilitation services provided to persons receiving DI benefits who medically recover while receiving rehabilitation services, whether or not the person worked full time for 9 months, and whether or not the person failed to cooperate in the rehabilitation program.

(12) Direction for Quadrennial Social Security Advisory Council.—Directs the next advisory council to study the medical and vocational aspects of disability using ad hoc panels of experts where appropriate. The study is to examine alternative approaches to work evaluation for SSI recipients, the effectiveness of rehabilitation programs, and other disability program policies, standards, and procedures. SSA must appoint the members by June 1, 1985.

(13) Staff attorneys.—Directs SSA to report, within 120 days of enactment, to the Committees on Ways and Means and Finance, on the actions taken to establish positions which enable staff attorneys to gain the qualifying experience and quality of experience necessary to compete for ALJ positions. The conference report states that it is assumed, given recent OPM actions, that statutory requirements for establishing specific positions are not required, and urges the Secretary to take all reasonable steps to see that the OPM actions result in SSA staff attorneys becoming qualified for GS-15 ALJ positions.

(14) SSI benefits for persons working despite impairment.—Extends sections 1619 (a) and (b) of the Social Security Act through June 30, 1987, and requires the Secretaries of HHS and Education to establish training programs for staff personnel in SSA district offices and State rehabilitation agencies, and to disseminate information to SSI district offices and State rehabilitation agencies, and to disseminate information to SSI applicants, recipients, and potentially interested public and private organizations. Effective retroactive to January 1, 1984.

(15) Frequency of continuing eligibility reviews.—Requires SSA to promulgate regulations establishing standards for determining the frequency of continuing eligibility reviews. Final regulations are to be issued within 6 months, and no individual may be subject to more than one periodic review during that time.

(16) Representative payees for Social Security and SSI beneficiaries.—Requires SSA to evaluate the qualifications of prospective payees prior to or within 45 days following certification, to establish a system to monitor annual accounting by the payees where payments are made to someone other than a parent or spouse living in the same household as the beneficiary, and to report to Congress on implementation, and annually on the number of cases of misused funds and the disposition of such cases.

(17) Measures to improve compliance with Federal law.—Requires the Secretary to federalize disability determinations in a State within 6 months of finding that a State is not in substantial compliance with Federal law and standards. Such a finding must be made within 16 weeks of the time a State's failure to comply first comes to the attention of the Secretary, during which period a hearing could be afforded to the State. The Secretary is directed to comply with current law requirements protecting employment of current State employees to the extent feasible, and is directed in

order to accomplish that end, to exceed any applicable personnel ceilings and to waive any applicable hiring restrictions.

(18) Severability clause.—If any provision of the act is held unconstitutional, the remainder of the act will remain in place.

(C) ISSUES IN IMPLEMENTING THE NEW LAW

Though the Social Security Disability Benefits Reform Act is a piece of legislation with an unprecedented degree of specificity in the history of the DI Program, its ultimate effect will largely depend on how SSA interprets the statutory language, and how this interpretation will translate into administrative instructions and guidance to State agencies. Predicting how this new law will be work out in day-to-day decisionmaking, and determining what effects it will have on the adjudicative climate is impossible at this point. Further, the Federal courts are inextricably linked to the many of the most important issues in the whole DI crisis, and a number of extremely complicated legal problems will undoubtedly unfold as this legislation is implemented.

The new medical improvement standard raises a number of important questions. First, Congress attempted to sidestep the problem of who bears the burden of proof in determining continuing eligibility to DI benefits by stating that the decision should be based on the evidence, and neutral to the fact that an individual had been determined eligible in the past. Though a creative solution to a problem that the House and Senate conferees could not agree upon, it raises a number of concerns for implementation.

How much evidence must be produced that shows an individual has improved over time? Can a consultative exam by a SSA physician, who has never examined an individual before, determine that this person's condition has improved in relation to the incomplete records the doctor may have available? Does the fact an individual is taking less medication than he had in the past constitute substantial evidence of improvement? If SSA has lost the individual's original case file, which is very frequently the case, what is the degree obligation of the individual to recreate that file? What if the individual cannot? Questions of this nature remain unanswered, and will depend largely on very concrete internal administrative procedures that SSA issues to the disability examiners in the field.

Conceptually, a medical improvement standard is a method of ensuring that if the Government is going to declare someone ineligible for benefits, there must be a coherent reason for doing so. In the version of H.R. 3755 that passed the House, the legislative language made it clear that SSA must demonstrate that there is improvement in a beneficiary's medical condition, and that this medical improvement enables the individual to work. There was a causal link between the change in condition and ability to work. In the final legislation however, this link is broken. SSA determines whether there has been any medical improvement, and if there has been any, it then determines whether the individual can work under current standards. There is no tie between the event—medical improvement—and the outcome—ability to work and hence denial of benefits.

In both breaking the causal link between medical improvement and capacity to work and sidestepping the issue of burden of proof, Congress attempted to establish what could be labled a medical improvement standard while evading the central philosophical issues at the heart of the matter. The basic process of matching an individual's medical records against current standards is the same—all that is new in the law is an elaborately designed hurdle, called medical improvement, that SSA must jump before it terminates eligibility. The fundamental problem of whether or not it is fair to terminate an individual without specifically identifying what change in circumstances led to a new capacity to work is not truly resolved. Nor does Congress make clear its position on whether or not entitlement to benefits establishes a presumption of disability that the Government must rebut.

How much of a procedural safeguard for beneficiaries will medical improvement prove to be? On the one hand, there has been a trend toward more lenient operation of the program in the past 1½ years, and this legislation must be interpreted as a statement of congressional dissatisfaction with extremely stringent administration. On the other hand, if this law is applied in a liberal fashion, literally hundreds of thousands of people denied benefits in the past 4 years could become eligible for benefits, and this would cost an enormous amount of money. With relatively narrow OASDI trust fund reserves, SSA will find itself constrained to not increase outlays for the DI Program substantially.

In addition to medical improvement, a few other provisions have the potential for significantly increasing the number of beneficiaries on the rolls. For instance, if the antiquated mental impairments listings are brought into conformity with current medical knowledge, and if an attempt is made to realistically determine whether mentally impaired people can work in a competitive environment, as is required by the legislation, a tremendous number of people will become entitled to benefits. In the past 4 years, it has been almost impossible to receive or sustain benefits on the basis of a mental disability. If this source of excluding people is opened up, it will cost a great deal.

The provision mandating that SSA consider the combined effect of a multiplicity of impairments could also serve to open doors to applicants and beneficiaries that has been shut in the past few years. If SSA allows State agencies flexibility in making realistic determinations of the "total" medical picture, it eliminates one method of terminating a whole class of "gray area" cases.

Another major area of uncertainty will be the response of the courts to the legislation. Though the medical improvement application scheme was drafted with the intention of cleaning the judicial slate by sending back to SSA all individual plaintiffs, all members of certified class action suits, and all named litigants in noncertified class action suits, it is very hard to predict what the role of the courts will be in the future. It is possible that judges will rule that unnamed members of noncertified class action suits can not be excluded from redress, and that SSA will have to reexamine virtually everyone terminated since 1981. Obviously, this would be costly. It may be that judges will not allow SSA to apply a new standard that is less favorable to beneficiaries than a previously court-ordered standard. There are a number of similar open questions that will have to be answered in the next few years.

C. PROGNOSIS FOR SOCIAL SECURITY

It is very unlikely that the Social Security system will encounter financial problems in 1985. The 1983 amendments have been successful in ensuring the solvency of the OASDI trust funds in the near term. Congress will face little pressure to legislate changes in the program to improve its financing.

However, in 1985, Social Security could come under congressional scrutiny as a source of savings to aid in a broad effort to reduce the budget deficit. It is possible, for instance, that Congress will eliminate or reduce COLA increases in the upcoming year as part of a larger, across-the-board "freeze" on Government spending. It is also possible that in the next few years Congress will consider proposals to extend the taxation of Social Security benefits to a larger number of beneficiaries or to modify the benefit formula for future beneficiaries. Though the OASDI Program does not fuel the deficit, because benefit expenditures are directly financed by payroll tax revenues, Social Security surpluses achieved by benefit cuts can be lent to the Treasury to help reduce the deficit. Because of the size of the Social Security Program, even small changes—such as eliminating a COLA increase in a year of low inflation—yield substantial savings.

In the DI Program, the focus in 1985 will be administrative, rather than legislative. SSA must draft regulations and write operating instructions in order to implement the legislation passed in 1984. It is very likely that this process of implementation will be controversial, with advocates for "stringent" administration contending that SSA is going too far in opening up the program, and advocates of a more generous program arguing that SSA is not going far enough. Finally, there are an enormous number of legal issues that have to be resolved, and the courts will likely continue to play an important role in the functioning of the DI Program.

Chapter 2

EMPLOYEE PENSIONS

OVERVIEW

In 1984, for the first time in several years, the topic of debate in pension policy shifted away from the overriding concerns in recent years of tax policy and Federal budget deficits. The 10th anniversary of the enactment of the Employee Retirement Income Security Act [ERISA] witnessed a rekindling of interest in the adequacy of employee pensions. This interest was manifest in the enactment of legislation to improve pension benefits principally for working women and divorced and surviving spouses, and in discussions at anniversary conferences of retirement equity and adequacy issues. Nonetheless, tax legislation enacted in 1984 continued to pursue increased Federal revenues by making small changes in the tax treatment of private pensions.

With the exception of the enactment of the Retirement Equity Act of 1984 [REA], the legislative accomplishments of 1984 were modest. Many important pension issues connected with the Federal program of benefit guarantees for both single and multiemployer plans remained unresolved. Waiting in the wings for 1985 was the effort to design a new pension system to supplement Social Security for new Federal employees recently covered under the program. The attention of the Members was focused instead on the growing Federal budget deficit and increasing activity on the question of tax reform.

The 99th Congress, however, may present an opportunity for more active consideration of pension issues. In 1985 Congress must begin crafting a replacement for the present Civil Service Retirement System [CSRS] for workers hired after December 1983. Many benefit adequacy concerns, such as improving pension portability, will be issues in the design of the supplemental pension for Federal employees. In addition, the Congress faces an agenda of unfinished pension legislation, such as the premium increase for single employer termination insurance, which must eventually be resolved.

A. PRIVATE PENSIONS

Two bills, very different from one another in purpose, were passed and signed into law during the summer of 1984: the Retirement Equity Act of 1984 [Public Law 98-397] and the ERISA-related provisions of the Deficit Reduction Act of 1984 [DEFRA] [Public Law 98-369]. The Retirement Equity Act of 1984 was finally passed by Congress on August 9, 1984 after nearly 2 years of concerted effort by its sponsors. This bill marked the first successful if cautious congressional action since 1974 to enhance pension participation and benefit adequacy. The second pension-related bill, the Deficit Reduction Act of 1984 [DEFRA], is more typical of post-ERISA legislation, which has generally been characterized by efforts to eliminate abusive use of ERISA-regulated plans for purely tax shelter purposes, to create or expand qualified plans designed for capital accumulation which are not retirement-savings specific, and to equalize the treatment of retirement plans for self-employed individuals with those provided to employees by corporate plan sponsors.

Another significant factor in the renewed interest in pension reform was the celebration of the 10th anniversary of ERISA. The Department of Labor [DOL] initiated a task force (the pension forum) to review pension issues and produce recommendations to the Secretary concerning the DOL's administration and enforcement responsibilities under ERISA. The subjects considered by the forum are administrative and generally policy concerns, rather than issues of benefit adequacy and security.

In another anniversary event, the Pension Benefit Guaranty Corporation [PBGC] held a 3-day conference of its own, focusing on the specific strengths and weaknesses of the Termination Insurance Program for defined benefit plans. The growing fiscal crisis being faced by the PBGC drew attention to issues which were debated during the final stages of the drafting of ERISA: Does plan insurance have a real present value to employees; is the termination of a pension plan, as a practical matter, a truly insurable event? The focus was again primarily on institutional issues.

The broadest-based discussions of private pension issues coming in the wake of the anniversary celebrations emerged at the September 11, 1984 conference sponsored by the Senate Special Committee on Aging and 14 cosponsoring organizations. This conference addressed a wide array of issues, from the policy implications of tax incentives for private retirement savings to the role of employer-sponsored plans in national retirement income policy. The conference program was supplemented by an Aging Committee information print, entitled "ERISA: The First Decade," reviewing the first 10 years of experience with ERISA.

The key issues in pension reform grow out of two primary questions of pension policy: What is the appropriate role of private pensions in securing retirement income adequacy, and how can tax benefits from pension plans be more equitably and efficiently distributed? Though Congress as a whole did not directly confront these broad themes during 1984, its focus on narrower issues produced REA and the pension-related provisions of DEFRA.

1. ISSUES

The private pension system as we know it today is the result of slow evolution over the last 75 years, and the convergence of two separate trends. In the unionized industrial sectors of the economy, pensions began to grow after the turn of the century as a humane means of retiring workers no longer capable of enduring the rigors and physical dangers of their jobs. With increasing frequency, pensions were also used as a means of rewarding long and loyal service with an employer. The Federal role in pension policy has been largely through the income tax system. Employers were allowed to deduct pension expenses when paid and employees were allowed tax deferral until the pension benefits were actually received. As a result, pensions have steadily grown as a principal means of accumulating tax-deferred savings for retirement.

Two undercurrents form the foundation of current Federal policy debates over private pensions. The first is the tension over benefit adequacy versus employer cost. Because pension benefit entitlement is work related, continuous work patterns result in higher benefits than discontinuous work or employment mobility. Originally, employers used to reward loyal employees and discourage job leavers. However, as pension plans proliferated, employees came to view pension benefit accruals as part of their total wage compensation package, not merely a gratuity for loyal service. Thus, pension forfeitures caused by an employee's failure to vest after long years of service were seen as unfair. Over the last 30 years Federal regulation of pensions has increasingly focused on an effort to improve benefit receipt and adequacy. The emphasis in the 1950's on reporting and disclosure to employers of plan features and investments and employee vigilance evolved into the enactment of the broad-based benefit guarantees of ERISA in 1974.

But even ERISA stopped short of requiring employers to provide pensions in a form which would completely eliminate pension forfeitures and close the remaining gaps in benefit adequacy. ERISA brought traumatic changes for some employers. Additional reforms were postponed out of concern that the private pension system would be devastated by farther-reaching requirements. Since that time successive attempts to renew those additional reforms have met with opposition. Some analysts have expressed concern that ERISA significantly increased the cost of providing pension benefits to employees, contending that further changes would push employers beyond the point where the maintenance of a pension plan would be economically feasible.

A second undercurrent of the debate over pension policy stems from Congress' concern that the tax benefits resulting from the favorable treatment of private pensions be equitably distributed. Nondiscrimination requirements in the tax law are designed to ensure that employers offering pensions make them available to all of their workers. However, pensions are usually designed to supplement Social Security and thus often skew their benefits to the middle and upper income workers who receive relatively little income replacement from Social Security. Employers are not obligated to offer pensions and many workers are not covered by a pension plan for at least part of a working career. Reform advocates contend that this uncovered portion of the work force is predominantly at the lower end of the wage spectrum and that the private pension system therefore suffer from a structural tax inequity which benefits primarly middle and upper middle employees. Recent amendments to the pension-related provisions of the Internal Revenue Code have been designed to reduce the accumulation of excessive pension benefits by the highly paid. This second tension between coverage-related tax equity and the voluntary and supplemental nature of the private pension system motivated much of the pension legislation enacted during the 97th and 98th Congresses.

(A) PENSION BENEFIT ENTITLEMENT AND ADEQUACY

(1) Obstacles to Pension Adequacy

Since the passage of ERISA in 1974, successive attempts have been made to address problems which Congress did not fully resolve at that time. Three problems remain which have been identified by analysts as the principal obstacles to greater retirement income adequacy through increased pension receipt: incomplete coverage of the work force by private pensions, restrictive vesting standards, and coordinating pensions with Social Security benefits.

(a) Pension coverage

Critics of the private pension system frequently point to imperfect coverage of the civilian work force as a serious problem. Though the nominal portion of the total labor force left uncovered varies depending on how broadly the relevant labor force is defined, under even the narrowest definition more than one-quarter of all workers are outside the scope of the private pension system at any given time. About 56 percent of the total civilian work force is covered by an ERISA-qualified plan. However, 72 percent of the work force defined by ERISA [pre-1984] minimum participation standards—age 25–64, with 1 year's tenure, working at least 1,000 hours a year—is covered.[1]

The gaps of coverage effect workers across sectors of the economy and are the result of structural characteristics of industrially differentiated labor forces. For example, certain highly unionized industries have over 90 percent work force coverage, while some labor intensive service sectors of the economy cover less than 40 percent.[2]

Pension coverage studies have concluded that if coverage is to be expanded within the context of a voluntary pension system, incentives for employers in these low-coverage economic sectors to sponsor pension plans must necessarily be increased. Some studies have suggested that incentives may not be sufficient. The President's Commission on Pension Policy concluded that the effectiveness of incentives for expanded coverage within the voluntary system were too limited and instead recommended a mandatory universal pension system [MUPS], including a tax credit for pension funding contributions instead of the current deduction and a minimun benefit equal to 3 percent of compensation.[3] In this way coverage would be expanded to the work force as a whole and employers with little or no profits in a given year would receive some tax relief from their annual pension expense.

The Commission recommendations have been widely criticized in the private pension community. Objections were voiced to the mandatory nature of the proposal on principle, because it would require an employer to provide part of its compensation to employees in a form which might not serve the employer's purposes. Others were primarily concerned about the financial burden that would be placed on small businesses, despite the availability of a tax credit. In the absence of the adoption of the Commission's recommendations, however, no alternatives have been proposed which would significantly expand pension coverage beyond its present parameters.

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[1] Employee Benefit Research Institute. Issue Brief No. 33. New Survey Findings on Pension Coverage and Benefit Entitlement. Washington, DC, August 1984, p. 23.

[2] Ibid., pp. 18, 19.

[3] President's Commission on Pension Policy. Coming of Age: Toward a National Retirement Income Policy. Washington, DC, February 1981, pp. 42, 43.

(b) Benefit entitlement

Roughly one-third of the employees in the civilian work force are currently entitled to future pension benefits—45 percent in the pre-REA ERISA-relevant work force.[4] However, many of those who are not now entitled to a pension will become entitled with additional years of work. A recent report for the American Council of Life Insurance prepared by ICF, Inc., based on a model of career benefit accruals, concluded that by the year 2007, approximately 82 percent of married couples and 58 percent of unmarried individuals will receive some pension benefits in retirement.[5] According to the analysis of this model, the failure to vest in pension benefits prior to retirement, and the disparity between projected benefit receipt for married couples and unmarried persons, is a result of employment discontinuities during an individual's working career. Those least likely to accrue benefits include the economically marginal, nonemployed spouses who are primarily family caretakers, highly mobile workers, and the long-term disabled.

The likelihood that an individual will retire with vested pension benefits is a function of an individual's average job tenure and the participation and vesting requirements of the pension plan he or she is covered under. Vesting remains a problem because average job tenure for many employees is less than the typical 10-year cliff vesting requirement which must be met to vest in nonforfeitable benefits.

Some analysts contend that short average tenure is often a consequence of employment in labor-intensive, low-paying sectors of the economy which are typified by low pension coverage as well. They argue that there is reason to speculate that lowering minimum vesting standards below 5—or perhaps 3—years might have only a marginal effect on future benefit entitlement because employees likely to have still shorter job tenures are probably not covered in any case.

(c) Benefit adequacy

Two generic obstacles to benefit adequacy remain for workers with vested pension accruals. First, some defined contribution plans allow employees to take part or all of their account balance prior to retirement, which encourages them to use these funds for nonretirement purposes. Second, pension plans can intergrate pension benefits with social security, thus reducing and in some cases eliminating pension benefits for employees with earnings below the Social Security taxable wage base.

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[4] EBRI Issue Brief No. 33, p. 23.

[5] ICF Incorporated. Future Retirement Benefits Under Employer Retirement Plans. Final report, prepared for the American Council of Life Insurance. Washington, DC, June 1984.

Preretirement distributions.—Many pension plans, particularly defined contribution plans, permit distributions of accumulated retirement funds when the employee terminates his employment under the plan. These distributions prior to retirement are frequently spent rather than saved. This loss of pension accruals can conceivably reduce the adequacy of pension benefits for highly mobile workers.

Integration of pensions with Social Security.—ERISA permits employers to take Social Security benefits into account when calculating an employee's pension benefit. Social Security is designed to replace a greater portion of preretirement income for low-income earners than middle- and high-income earners. Therefore, full integration permits an employer to do the opposite for pensions: provide higher replacement rates for income above the social security wage base.

Pension integration can effectively negate the progressive benefit formula used to calculate Social Security benefits by offsetting pension annuity payments with Social Security benefits to produce a uniform preretirement replacement rate for employees across income levels. The result is that lower earning employees—who have a larger portion of their preretirement income replaced by Social Security—can be integrated out of a pension altogether, under some rules, despite years of service for the employer. Employees who view pension accruals as part of their total wage-compensation package view the failure to ultimately receive any pension as unfair.

Those most in need of improved income adequacy are precisely those effected by pension integration. Integrated plans, when viewed in isolation from Social Security, skew benefits in favor of employees with earnings above the Social Security taxable maximum. Employers argue that to eliminate integration would result in low-income workers receiving in excess of 100 percent of preretirement income in retirement. Some analysts suggest that what is apparently needed is an approach to integration based on a progressive target replacement rate, rather than the flat replacement rate still available to plan sponsors.

(2) Specific Gaps in Pension Income Adequacy for Women

An analysis of the income of older Americans suggests the likelihood that an individual will receive at least some pension income to supplement other sources during retirement is directly linked to the individual's employment patterns over his or her lifetime.[6] Those least likely to receive adequate pension benefits in retirement have a work history which is discontinuous or sporadic, or they have none at all: the highly mobile, the infrequently employed or nonemployed spouse and the socially and economically marginal—including the long-term disabled.

Discontinuous work patterns reduce women's pension benefits in several ways. Despite shifting family roles, women are still more likely than men to be primary family caretakers. While women constitute a high percentage of the work force between the ages of 18 and 25, their work force participation begins to decline thereafter as a result of marriage and childbirth. Under ERISA standards, prior to 1984, employers were under no obligation to include those under 25 in their pension plan. Significant numbers of women left the labor force for short or long breaks in service before they had accrued any significant level of vested benefits.

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[6] ICF Inc. Future Retirement Benefits Under Employer Retirement Plans, p. A-3.

The effect of the discontinuous work history is compounded by two additional factors. Women are frequently employed in service-provider and retail sectors of the economy, where average job tenure is short and pension coverage is not widespread. Perhaps even more significant is the continued wage distribution differential between men and women, which will result in lower benefit accruals for women because pensions are a function of salary.[7] The aggregate effect of these factors has been that couples approaching old age typically rely on the husband's accrued pension benefits to supplement their retirement income.

Since many married women do not accrue significant pensions of their own, they may be financially devastated when a husband's death causes the loss of entitlement to his pension benefits. Prior to the enactment of the Retirement Equity Act of 1984 [REA], pension plans were not required to offer mandatory joint and survivor coverage until the plan participant reached normal retirement age. Although a joint and survivor annuity option could be selected at early retirement age—or 10 years prior to normal retirement age, whichever was later—it generally had to be affirmatively selected by the plan participant with the spouse having no legal role in the decision. In addition, the spouse did not have to consent to waive the mandatory joint and survivor benefit at normal retirement. Frequently, widowed spouses found their partner's vested pension rights expired at the partner's death, either because the death occurred only a few days short of early retirement age or because joint and survivor benefits had not been selected. Many plan participants are reluctant to take the required benefit reduction for preretirement joint and survivor protection, gambling their spouse will not be widowed before the participant reaches retirement. Sometimes both partners simply assume the spouse is entitled to the partner's vested benefits. It therefore comes as an unwelcome shock when a surviving spouse discovers that pension entitlement lapsed following the plan participant's death.

The obstacles faced by women in accruing adequate pension benefits are, to an extent, shared by highly mobile workers of either sex. Although the principal vocal support for reform in the context of REA came from women's groups, there has been continuing concern about the interests of mobile workers generally, whether men or women, and their inability to accrue adequate pensions over their work lives.

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[7] Employee Benefit Research Institute. Issue Brief No. 33, pp. 9, 10.

(3) Legislative Response: Retirement Equity Act of 1984

Retirement equity initiatives introduced by members of the Senate Finance Committee at the beginning of 1983 were reported by the committee as a pension equity package early in that year. Simultaneously, similar legislation was considered by the House Committee on Education and Labor. By late summer, four related predecessor bills were condensed into two: S. 1978 and H.R. 4280. Late in 1983, the Finance Committee initiative was attached to a House bill and passed by the unanimous consent of the Senate.

Final passage of REA took longer than its supporters had hoped. Although congressional activity was intense at the end of 1983, once the first session ended the momentum slowed and the legislation was not seriously considered again until the late summer of 1984, as time began to run out on the 98th Congress and the elections approached. Whirlwind negotiations during the first week of August finally produced a compromise bill, which was quickly passed by the Senate and House.

(a) Summary of provisions

REA contains three provisions designed specifically to increase pension benefit adequacy: the extension of joint and survivor protection for spouses; liberalization of ERISA minimum standards to take into account employment patterns of workers with discontinuous work histories, typical of many working women; and clarification of the treatment of pension benefits pursuant to a divorce. The act also seeks to protect beneficiary rights by requiring the communication of important and useful information to plan participants, and makes other technical changes.[8] Though women's organizations were the principal advocates of these reforms, REA was intended to provide pension equity to employees with discontinuous employment patterns regardless of sex. In some instances, it may be of equal or greater benefit to men than women.

Joint and survivor benefits.—In general, REA requires pension plans to provide automatic joint and survivor protection to participants with vested benefits. This coverage must be provided to terminated participants as well, and includes preretirement death benefit protection. Additionally, vested former employees who terminated with at least 10 years of service after 1975 but before REA was enacted will be able to elect preretirement death benefit protection. Profitsharing and stock bonus plans are exempted from this requirement if they pay the full vested account balance as a

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[8] Summarized briefly, REA (1) increases, from $1,750 to $3,500, the present valued of accrued benefits that a plan participant may now be required to accept in the form of a lump-sum payment; (2) defines what constitutes an optional form of benefit; after July 30, 1984 such early retirement and retirement-type benefits cannot be reduced or eliminated to the extent they are already accrued; there are, however, a range of nonretirement benefits to which the rule does not apply including medical, plant shutdown, and death benefits as well as social security supplements; (3) requires that statements of the employee's total and nonforfeitable accrued benefits also include a notice that certain benefits may be forfeitable if the participant dies before a particular date; (4) contains a new requirement that a plan administrator who makes a qualifying rollover distribution of benefits to a participant must give the recipient a notice that the distribution will not be taxed currently to the extent that it is transferred to another qualified pension plan or is deposited in an IRA—so long as the rollover is completed within 60 days of the distribution; such notice must also contain an explanation of the 10-year income averaging and capital gains treatment if such would be applicable to the distributed amount.

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lump-sum death benefit. An employee can waive this annuity option, but only with the written consent of his or her spouse.

Assignment of benefits in divorce cases.—Although pensions are subject to prohibitions against the assignment or alienation of benefits, certain exceptions are made by IRS regulations for plans which are complying with court orders to distribute benefits to meet a participant's alimony or child support obligations. The new law clarifies the circumstances under which plans may honor such domestic relations orders, as well as the tax consequences of plan distributions made pursuant to such allocations.

Breaks-in-service rules.—A break in service is defined as any year in which a plan participant does not complete more than 500 hours of work. REA contains new break-in-service rules for three specific circumstances.

First under the general rule for reemployed nonvested participants, past and future service must be aggregated if the employee's intervening absence does not exceed 5 years. For longer service interruptions, the prior rule of parity still applies: The employer does not have to aggregate past and future service if the length of the break in service equals or exceeds the employee's aggregate number of years of service before the break in service. Second, for vesting purposes in the case of a participant's prebreak account under a defined contribution plan, if the break in service is less than 5 years, then service after the break must be taken into account in determining when the forfeitable portion of a nonvested participant's account balance becomes nonforfeitable. Finally, participants who are granted maternity, paternity, or adoption leave must be credited with at least 501 hours of service so that they do not incur a break in service.

Participation age.—Under prior law, an employer generally could not preclude an employee from participating in a pension plan once he or she had attained the age of 25 and completed one year of service—an exception existed for plans which vest the employee's entire accrued benefit after 3 years. Subject to collective bargaining agreements ratified prior to the passage of REA, employees attaining age 21 with 1 year of service are now entitled to participate in the plan—although the exception for plans fully vesting in 3 years is still valid.

Vested years of service.—In the past, a pension plan could disregard years of service with the employer prior to the worker attaining age 22. Beginning with plan years commencing after December 1984—subject to collective bargaining agreements—only years of service prior to age 18 can be excluded.

(4) Policy Implications

The short- and long-term implications of the enactment of REA are subject to some dispute. Its significance will be considered here from two different perspectives: Its impact for spouses who are not primary family income providers, and an analysis of REA's rationale for amending ERISA minimum standards.

(a) Spousal benefit protections

Several provisions in REA represent an effort to protect the retirement interests of spouses who are not the primary earner for their families. REA recognizes that pensions can play an important role in a family's total resources, and attempts to minimize the possibility that a change in marital status—due to death or divorce—will result in inadequate retirement income. The changes and clarifications provided by the sections dealing with joint and survivor benefits and domestic relations orders were intended to lessen the likelihood that spouses will be denied an adequate share of their partner's retirement benefits accidentally or without their prior consent.

These new provisions may create their share of inconveniences for plan sponsors and participants. Some employers have complained, for example, that many employees will opt out of joint and survivor benefits, making the automatic coverage mandated by the act an increased administrative cost yielding only marginally better protection. Department of Labor statistics show that prior to REA about 35 percent of all defined benefit pension plan beneficiaries received their payments in the form of a joint and survivor annuity. Only experience will determine whether extending mandatory preretirement to all vested participants joint and survivor coverage and requiring spousal consent in waiving survivor benefits will substantially increase the prevalence of survivor pensions. In addition, the joint and survivior provisions might work against the wishes of a spouse if cases where an uncooperative partner refuses consent to the designation of another individual as beneficiary. However, supporters of the bill argued that on balance the new requirements will produce immediate benefits for plan participants, outweighing their costs.

(b) Rationale for amendments of ERISA minimum standards and their likely effect on pension benefit receipt

The women's organizations advocating REA's changes in ERISA minimum standards explicitly linked their argument to work force mobility, since the average tenure of young working women was perceived to be shorter than that necessary to accrue significant pension benefits under pre-REA standards. However, the lowered participation and vested service standards set forth in REA and the new break-in-service rules will be of equal or greater benefit to working men as well.

ERISA's original minimum standards were modeled on a work force pattern of relatively stable employment. Part-time employees and those assumed to have very high turnover rates were not included in the model. For example, plans were not required to extend participation to employees less than 25 years of age because most younger employees were thought to turn over employment so frequently as to rarely vest in a pension benefit.

Three of REA's provisions may be understood as an effort to broaden ERISA's model of work force participation to reflect the interests of younger or more mobile workers. The participation age, vested service and break-in-service portions of REA increase the probability that an employee's years of credited service will be co-extensive with his or her job tenure. For participants in defined contribution plans with typically short vesting schedules, the potential gain from the REA reforms comes directly in the form of additional years of service for which contributions are made to the employee's account balance. For participants in 10-year cliff-vested defined benefit plans the potential gain is indirect.

The law adds a maximum of 4 years service credit by lowering to 18 the age at which service must be counted for vesting purposes. Although a worker's total employment tenure must still equal 10 years to vest under plans which meet only current 10-year minimum standards, employees who began work for their present employer at early ages will now meet the plans vesting retirement more rapidly. Likewise, the break-in-service rules will only aid workers who return to the same employer and meet the vesting retirement. To the extent that men might have longer average employment tenures than women, they may be more likely to realize increased benefits from these provisions than their counterparts.[9]

When a participant in a defined benefit plan leaves employment after accruing benefits with a present value of $3,500 or less, the employer is permitted to distribute those benefits to the worker in the form of a lump-sum payment rather than an annuity commensing at retirement. This is especially likely for young employees on the middle to lower end of the salary scale whose benefits would be discounted over the 30 or more years remaining before reaching normal retirement age. REA actually increased the number of employees who will be subjected to mandatory cash outs by doubling the prior $1,750 present value limitation. Studies of savings behavior suggest that few workers in the 21 to 35 age cohort can be expected to save small pension distributions for retirement.

(5) Unresolved Initiatives

In late 1984, Senator Kennedy and Representative Ferraro announced their intention to introduce a vesting-integration-portability [VIP] pension proposal, designed to address remaining gaps in pension protection, adequacy and equity in the areas of minimum vesting standards, the integration of pension benefits with Social Security, and the portability of pension credits for mobile workers.

The basic VIP proposal contains three elements principally designed to increase benefit adequacy for pension participants: a 5-year minimum vesting standard; the creation of portability accounts, which mobile employees can use to aggregate on-demand lump-sum distributions from successive defined benefit pension plans as they move from one employer to another; and a mandated minimum benefit which can not be integrated with Social Security. Each element will be briefly considered.

While accelerating vesting beyond the current 10-year minimum standard will diminish pension benefit forfeitures, this alone is not sufficient to guarantee significantly increased levels of retirement savings. The new nonforfeitable benefits created by a 5-year vesting standard for employees changing jobs after tenures of from 5 to 10 years would in many instances be very small when discounted to their present value. Young workers, and those at the lower end of the salary scale, would be especially susceptible to involuntary lump-sum distributions at the termination of their service. Under current law, nothing prevents these employees from spending their distributions rather than having them rolled over into a tax-qualified retirement plan or account.

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[9] A preliminary Employee Benefit Research Institute simulation of the effect of REA on participation and vesting, which is subject to revision, tentatively suggests that REA will expand participation to slightly more women than men, but that men would experience a slightly greater increase in the incidence of vesting than women.

The VIP proposal would grant employees the right to receive on-demand lump-sum distributions of accrued benefits below a present value of $7,000. This will benefit employees only if the lump sum is not spent and if the employee can beat the interest rate and mortality assumptions used to calculate the present value of the distribution. There is no guarantee that all employees are capable of making investments in a fluctuating market which will outperform the assumptions of their plans.

The integration of pension plans is another issue of concern to some employees. Integration methods available to employers sponsoring defined benefit pension plans can offset some of the progressive replacement of benefits provided by Social Security. Low-income employees generally need a higher portion of their preretirement income replaced than upper-income individuals to maintain an adequate standard of living in retirement. Substantial integration may result in an aggregate replacement rate from Social Security and pension benefits which is too flat to meet social policy objectives.

Past efforts to restructure integration have failed, however, in part because of the complexity of these provisions and the possible cost for plans of changing the rules. From the viewpoint of benefit adequacy, the minimum benefit included in VIP would preserve some of the progressive structure of Social Security, but presents new problems of its own.

The effect of a minimum benefit in a defined benefit plan might be to disproportionately penalize long-term, low-income workers relative to employees with comparatively short tenures—especially since VIP would lower vesting to 5 years. After 10 years a portion of the additional pension accruals of low-wage plan participants would be exposed to integration while the accruals of short-term, higher wage participants would generally fall within the scope of the protected minimum benefit level. If one purpose of a pension plan is to reward long service, a minimum benefit would undermine this purpose by creating a countervailing incentive favoring work force mobility.

The vesting-integration-portability framework of this proposal calls attention to acknowledged weaknesses in ERISA's participant protections for mobile and low-income plan participants but it fails to address the lack of adequate coverage of sectors of the civilian work force by employer provided pension plans.

(B) TAX EQUITY AND THE TREATMENT OF PENSIONS

The term "horizontal tax equity" is sometimes used to describe the principal that similarly situated taxpayers should receive the same tax treatment. In our private pension system, the availability of a pension plan in which a worker can participate is at his or her employer's discretion. As a result of the voluntary nature of the private pension system, a substantial portion of the American labor force does not participate in a pension plan at any given point in time. Thus one worker may receive a tax benefit from pension plan participation while a similarly situated worker, whose access to pension plan participation is not within the scope of his or her control, may receive no tax advantage at all.

Another source of perceived inequity arises from the manner in which some pension plans are integrated with Social Security. Social Security benefits are calculated to replace a high percent of preretirement income for individuals with low career earnings; the replacement rate gradually declines as income increases. Private pensions can be designed to provide greater replacement of income earned above the Social Security wage base than below, so long as the percent of income replaced by total benefits—Social Security plus the pension—is the same for all employees.

An analysis of lifetime pension-related tax benefits for workers under private pensions, prepared by the Employee Benefit Research Institute [EBRI] from Census Bureau data, offers some insights into the current distribution of Federal pension tax benefits. EBRI's model simulates the share of tax expenditures for private pensions that employees in particular income groups are likely to receive over their lifetimes. Persons in middle-income groups—$20,000 to $50,000 annually—are projected to receive 57 percent of their age group's lifetime pension-related tax benefits. Although low-income taxpayers—up to $20,000 annually—made up 61 percent of the simulated work force, they were projected to receive only 24 percent of their age cohort's lifetime benefits. Workers with incomes less than $30,000 annually constituted 81 percent of the model's population, but accounted for only 44 percent of total tax expenditures.

Some of this effect is a consequence of the fact that pensions supplement Social Security and are thus directed to higher income employees who receive lower income replacement through Social Security. In addition, tax expenditures on pension benefits for high-income employees may be necessary in order to encourage employers to provide tax-qualified pension plans for all of their employees. The simulation suggests that under current policy, for every $3 Congress spends on pension benefits for members of this age cohort with income above $20,000, it spends $1 on workers earning less than $20,000. The difference is principally attributable to the fact that low-income wage earners participate in and accrue vested benefits under pension plans at a comparatively lower rate than high-income workers. If Congress wishes to direct a larger portion of pension-related tax expenditures to low-income taxpayers, it will have to increase the rate of pension plan participation and vesting in this income group.

(1) The Balance of Congressional Activity

In recent years, pension legislation successfully making its way through the Congress has been characterized by observers as arising from the tax committees' special concerns. The loss of Federal revenues from the tax-deferred treatment of pensions is argued by critics of the private pension system to be unjustifiable given the present distribution of private pension benefits among lower income workers. This criticism has been sharpened during the last year due to mounting Federal budget deficits.

There is also a perception among some observers that the private pension system provides benefits primarily to the wealthy. Since 1982, this perception has been reflected in a series of amendments to the Internal Revenue Code which reduced and then froze the maximum benefits payable by and contributions payable to qualified plans and created top-heavy rules for plans which provided a substantial portion of their benefits to owners or key employees. Such efforts might be characterized as attempts to eliminate perceived abuses rather than expand the private pension system to alleviate distributional inequities. Driven by concerns that pension plans not serve as excessive tax-sheltering devices, recent amendments have not addressed basic underlying equity issues of coverage, future benefit receipt or the coordination of pension benefits with Social Security.

(2) Legislative Response: Deficit Reduction Act of 1984

The pension provisions of DEFRA can easily be viewed as part of a larger ongoing process, begun with the Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA], to reevaluate the broad tax-deferred or tax-exempt treatment of employee benefits under the Internal Revenue Code. Prior to the passage of TEFRA in 1982, post-ERISA tax legislation had generally expanded tax-favored treatment for a wide range of benefits. Within the scope of ERISA, these liberalizations included successive incentives for the creation of employee stock ownership plans [ESOP's], the authorization of cafeteria plans under the newly enacted section 125 of the Internal Revenue Code, the growth of salary-reduction financing of employer-sponsored plans under IRC section 401(k), and the gradual expansion of contribution and eligibility rules for IRA's. The recent scrutiny is based on two factors: The concern that favorable tax treatment is not justified where the benefits are distributed inequitably, and a more recent desire to check continued erosion of the tax revenue base in an effort to bring the Federal deficit under control.

The Deficit Reduction Act of 1984 [DEFRA], signed into law by the President on July 18, 1984, makes several changes in the tax treatment of employee benefit plans, including qualified pension arrangements. DEFRA also contains a controversial provision relating to the Multiemployer Pension Plan Amendment Act of 1980. MPPAA has been a source of heated debate since its enactment. Perhaps its most disputed aspect has been the retroactive application of liability for pension funding deficiencies to plan sponsors which withdrew from multiemployer plans during a window period between the bill's effective date, April 29—when the bill left committee—and the date on which it was actually passed, September 26, 1980. Only days after the U.S. Supreme Court upheld the retroactive effective date, DEFRA was enacted with a repeal provision mooting the Court's opinion and making it one of the shorter-lived decisions in Supreme Court history.

Among the new rules created by DEFRA are four provisions effecting what are broadly considered to be pension plans under ERISA. They were part of a larger reexamination of employee benefits: health, disability, severance, and others. The arrangements scrutinized, along with traditional pension plans, were voluntary employee beneficiary associations [VEBA's] and cafeteria plans. Together these changes reflect both revenue loss and tax abuse concerns.

(a) Maximum benefit and contribution limits

Since the passage of TEFRA in 1982, the maximum allowable contributions to defined contribution plans and benefits payable by defined benefit pension plans under section 415 of the Internal Revenue Code have been limited to $30,000 and $90,000 respectively. Although these limits were to have been indexed again beginning in 1986 to take into account post-1984 inflation, DEFRA extended the freeze on the 415 limits until 1988, when they will be indexed for inflation occurring after 1986.

The level at which an incremental increase in the amount of tax-deferred benefits supplied to employees becomes excessive is subject to debate. Although the effect of the continued freeze is difficult to quantify, it might well be uneven across income groups. At some point rising employee wages will begin to push the pension accruals of middle management as well as upper income employees against the section 415 ceiling. Some analysts speculate that a company's highest paid employees often do not feel this loss, as they are already covered by a supplemental nonqualified pension plan which can be expanded to make up the difference. Whether such supplemental benefits would be extended to lower tiers of employees is less certain.

(b) Employee-funded qualified plans

Under ERISA, a plan can be funded principally or solely by employee contributions, and the withdrawal of nondeductible employee contributions are permitted without penalty. For the purposes of taxation, the first withdrawals are deemed to be the nondeductible contributions, and only after they are exhausted are withdrawals deemed to be the tax-deferred earnings thereon and subject to taxation.

Exploiting a potential in this distribution rule, some consultants began marketing what were in essence tax-sheltered interest-bearing checking accounts: the plans were tax-qualified under ERISA but permitted unlimited withdrawals so long as the balance exceeded the amount of the account's accumulated interest. Congress recognized that these abusive plans were not in any sense designed to provide retirement benefits in the manner ERISA contemplates, but existed only to take advantage of an unintended loophole. Rather than attempt to prohibit these plans, DEFRA simply reversed the treatment of distributions. If substantially all of a plan's funds come from employee contributions—that is 85 percent or more—then the first amounts withdrawn, including any loans, are deemed taxable withdrawals.

(c) New rules affecting pension plan distributions

For tax minimization and general estate planning purposes, many pension plan participants would prefer to delay the commencement of their benefit payments or distribution of retirement account balance for an indefinite period. Realizing that this would have an adverse effect on the tax system, Congress has long insisted that payments and distributions begin no later than a specified, determinable date; a severe nondeductible penalty excise tax is otherwise assessed. These rules were tightened even further by TEFRA in 1982.

In exchange for the repeal of the $100,000 estate tax exemption for distributions from qualified pension plans, DEFRA liberalized the permissible timing of plan distributions. Effective January 1, 1985 rules similar to the pre-TEFRA treatment of distributions will be implemented. Distributions may now be made over the life or life expectancy of the participant or the participant and his or her beneficiary, who need not be a spouse. Distributions which commence after death may now extend over the life or life expectancy of the participant's beneficary, who again need not be a spouse. The new rule is a response to complaints of many who preferred to receive joint and survior distributions with a beneficiary other than a spouse, often the case for single individuals.

DEFRA also permits the rollover to an IRA of the taxable portion of a partial distribution representing at least 50 percent of the balance of an employee's account; favorable lump-sum tax treatment is not available for subsequent distributions. In this way, employees who wish to invest their retirement savings in an alternative investment are free to transfer a portion of their account balance to an IRA. However, the 50-percent requirement was apparantly intended to prevent employees from rolling over standard periodic payments to shelter them from taxation.

(3) Policy Implications

When Congress changes the tax treatment of pension plans, it does not simply alter available tax exclusions, deductions and credits, or effect only corporate accounting. Because pension plans must be established subject to a written plan and funded by a pension trust, tax changes often require that the plan and trust documents be amended. Each time the tax committees—or any committee—successfully initiates pension legislation, plan sponsors and benefit consultants object not just on substantive grounds, but because of the administrative burden of amending plans to conform with the changes. To the extent that frequent legislation creates an environment which does not appear to be conducive to pension plans, critics argue that legislative activity may have some impact on growth in the total number of pension plans. This factor, along with the effects of cyclical downturns in the economy, may be contributing to the apparant stagnation in the relative growth of the private pension system in recent years.

Should tax simplification efforts find sympathy in Congress—especially if attempts are made to broaden the revenue base in ways that are not revenue neutral—legislative observers suggest the favorable tax treatment currently enjoyed by ERISA-qualified plans will be as vulnerable as other principal tax expenditures. The failure of the tax simplification movement would not guarantee a year without pension-related tax changes, however. While the impact felt by pension plans was less severe in 1984 than that experienced when TEFRA created top heavy rules and cut the section 415 limits in 1982, the inclusion of additional pension amendments in DEFRA suggests that the tax committees have a continuing interest in modifying pension tax provisions.

2. ERISA ADMINISTRATION

When the final structure of ERISA was being determined by Congress in 1974, certain provisions were the subject of extensive debate. The compromise which was finally struck left gaps, not only in the protections afforded plan participants, but in the regulatory structure being created to administer and enforce the act. These structural weaknesses began to emerge shortly after ERISA's enactment, and resulted first in an Executive order in 1978 reorganizing the administrative functions carried out by the executive branch agencies charged with oversight of the act, and then with the completion of the multiemployer termination insurance program in 1980. Since then new flaws in the fabric of ERISA have begun to cause concern. For example, the impending insolvency of the single employer termination program and the growing trend of so-called overfunded pension plan terminations received considerable attention from the pension community in 1984.

Such perceived weaknesses in ERISA's regulatory framework have prompted some Members of Congress to advocate a concentration of Federal pension enforcement and policymaking into a single agency. The divided committee jurisdiction over pensions in Congress, a general lack of broad-based congressional interest in pension issues since 1974, and the fragmented administration of ERISA in the executive branch have resulted in what some critics charge is uncoordinated and ineffective retirement income policy. Among those bills which expired with the close of the 98th Congress were proposed administrative reforms intended to address many of these perceived limitations. These initiatives include the reorganization of Federal pension regulation, administration and enforcement into a single employee benefits agency; changes in the single employer termination insurance system and the treatment of excess assets resulting from plan terminations; the creation of a Federal annuity program for participants who lost benefits due to pension plan terminations prior to the creation of the present termination insurance program in 1974; and other pension investment and adequacy proposals.

(A) SINGLE EMPLOYER TERMINATION INSURANCE REFORM

Once Congress enacted the Multiemployer Pension Plan Amendments Act in 1980, attention was gradully shifted to the need to reexamine single employer termination procedures. In ERISA's present form substantial financial incentives exist for plan sponsors to terminate their defined benefit pension plans independent of any consideration relating to the best interests of plan participants and beneficiaries. The extensive process of examining abusive plan terminations continued during the second session of the 98th Congress, but failed to produce a politically viable package capable of closing the loopholes in the current program.

(1) Issues

Any plan termination represents a potential threat to the interests of plan participants and beneficiaries. Even though vested benefits are generally insured by the Pension Benefit Guaranty Corporation [PBGC], the termination insurance program does not protect all benefit accruals under plans terminated with insufficient assets to pay plan liabilities, but sets limits on the maximum benefit payable. Even if a terminated plan is subsequently replaced, the benefits under the new plan may not be suffieniently generous to make up the shortfall between total benefit accruals and the insurable maximum payable to PBGC. Thus it is usually in the interest of plan participants and beneficiaries for the employer to resist terminating an underfunded pension plan unless the failure to do so would precipitate the plan sponsor's bankruptcy.

It is also in the interest of other plan sponsors to limit terminations of underfunded plans to those caused by unavertable business necessity. At present, the PBGC termination insurance program is funded by a flat-rate premium—per employee—rather than a risk-related premium as is ordinarily paid to an insurance company. The current PBGC Program is thus not a true insurance program, but an indirect means of redistributing the cost of unfunded reliabilities of terminated plans amonst remaining employers. To the extent that such terminations are not the result of business necessity, the program requires responsible employers to subsidize the unfunded pension liabilities of less responsible employers.

Abusive plan terminations by economically viable employers, designed to dump pension liabilities on the termination insurance system, can also have a serious detrimental impact on the continuing solvency of the PBGC. Already strained by terminations caused by a flagging economy, abusive terminations threaten to worsen an already serious long-term trust fund deficit. Although the PBGC has a claim against the employer for one-third of its net worth, unfunded pension liabilities frequently exceed this amount. In such circumstances the employer still has a financial incentive to terminate the plan, and the PBGC under current law cannot proceed to collect the full value of the insurable benefits paid.

It has been estimated that unless PBGC receives an increase in the premium paid by plan sponsors, its cumulative deficit could easily exceed $900 million by 1987. The PBGC trust fund is financed primarily by such premiums as are collected, plus amounts it can recover from terminating plan sponsors. The premium was set at $1 per capita in 1974, then raised by Congress to $2.60 in 1978. It has not been increased since. Although a premium rate increase was included in legislation introduced in both the House and Senate, no relief was forthcoming in 1984. The longer an increase is delayed, the greater the increase must be to completely retire the ever-mounting financial drain on the trust fund.

(2) Legislative Activity

In May 1983, Senator Nickles, chairman of the Pension Subcommittee of the Committee on Labor and Human Resources, introduced an initial reform package [S. 1227] at the request of the administration. The bill incorporated the recommendations of a joint agency task force set up in November 1982. When employers objected to S. 1227 because it ostensibly limited their ability to terminate plans for legitimate reasons without necessarily preventing abusive terminations, a compromise approach [H.R. 3930] emerged from the Labor-Management Subcommittee of the House Committee on Education and Labor in September with the bipartisan support of Representatives Clay and Erlenborn.

Unlike S. 1227, H.R. 3930 was designed to permit an employer to voluntarily terminate a pension plan at any time, but would effectively shift the insurable event that triggers PBGC benefit guarantees from plan termination to the employer's proof of financial distress. As this second-generation initiative proceeded out of the subcommittee in the spring of 1984, it became the basis for a substitute version of S. 1227, though it was substantially altered from its original House-devised form. It was at this point that the so-called private sector consensus which had generated the House compromise deteriorated, and the session expired without any further progress being made.

It is not clear at this time whether a renewed private sector concensus can be reassembled when this initiative is—presumably—reintroduced in the 99th Congress. Some employers have indicated an unwillingness to support a premium increase unless such is accompanied by adequate reforms. Labor unions have consistently bargained for some control over the decision to terminate a plan. Above all it is imperative that a lesson be learned from past experience with the multiemployer amendments, however. The danger in continued delay of necessary single employer reforms is the possibility that escalating needs for premium increases will reach a political barrier beyond which further increases are impossible. The only apparent alternative to sufficient premium increases would be to cut back the PBGC's insurable benefit levels, a partial solution incorporated into MPPAA. The consequences for retirees dependant on pension plans trusteed by PBGC are direct and obvious.

(B) TERMINATION OF "OVERFUNDED" DEFINED BENEFIT PLANS

(1) Issues

During recent years the termination of a well-funded defined benefit pension plan has emerged as a common technique used by employers to raise capital for a corporate exigency. So-called overfunded pension plans are those which have more accumulated assets than are necessary to pay accrued benefit liabilities at termination. Under current law, the only way an employer can make use of accumulated assets in excess of present plan liabilities is to terminate the plan outright and recapture any remainder after those liabilities are satisfied.

Although overfunded pension plans have been terminated by some plan sponsors because of their financial reorganization or insolvency, a singificant portion of such terminations have taken place even though the employer was in no way financially distressed. Any plan termination is a potential threat to a worker's future retirement income security. The possibility exists that the plan will not be replaced, or that a subsequent plan will provide less generous benefits than the employee expected, and perhaps relied on, when planning for retirement. In some cases, the retirement income security of plan participants is being jeopardized for reasons which are unrelated to the benefits themselves or the plan sponsor's ability to continue contributions to fund the plan.

(2) Legislative Activity

Despite hearings held by the House Select Committee on Aging in 1983 and a hearing before the Pension Subcommittee of the Senate Committee on Labor and Human Resources precipitated by Senator Metzenbaum, attempts in both the House and Senate to impose a temporary moratorium on further terminations of overfunded plans were largely ignored. Just before the House of Representatives adjourned at the expiration of the 98th Congress, Representative Roybal introduced for comment a comprehensive bill [H.R. 6909] designed to eliminate the recapture of surplus assets after termination except in instances of verified business necessity. Although the bill will be reintroduced in the 99th Congress, at this time there is no indication that the issue will be taken up on the agendas of the committees with ERISA jurisdiction.

(C) ADMINISTRATION AND ENFORCEMENT

In June 1983, Representative Erlenborn introduced H.R. 3339, the Employee Benefit Administration Act of 1983. The principal concern of the bill's sponsor is the failure of the agencies with jurisdiction over ERISA to effectively administer and enforce the act or develop coordinated long-range policy. Thus, the bill would condense the current disparate Federal regulatory authority over private pensions into a single employee benefit administration. Although the bill did not receive any additional consideration in 1984, recent events suggest that interest in the proposal will be renewed.

Among the recommendations of the ERISA Advisory Council to the Secretary of Labor in December 1984, presented in the form of a report of the Department of Labor Pension Forum, was the unification of current Federal administration of ERISA into a single agency. This recommendation parallels the general concern among critics of the current agency structure, reflected in H.R. 3339, that ERISA is not administered efficiently due to lack of coordination between the Department of Labor, the Department of Treasury, IRS and PBGC, and other agencies with related enforcement authority—including the Department of Justice and SEC. At this time, the principal obstacle to the bill's reintroduction in the 99th Congress is the retirement of Representative Erlenborn, the sole remaining author of ERISA who was still in Congress in 1984, from public service.

Another area of concern centers around the investment of pension plan assets to make funds available for home mortgages. In the past, technical restrictions made it more difficult for plan trustees to make long-term investments in mortgage pools than in other comparable investment vehicles. New regulations issued by the Department of Labor eased the problem, but only to a limited extent. Therefore bills were introduced in the House and Senate—including H.R. 4243 and S. 1179—to remove these unintended technical barriers.

H.R. 4243 was designed to have a much broader effect. Several major construction unions have sought relaxation of the restrictions on pension trust investments in home mortgages so that employment for union members can be stimulated by investing their own pension fund assets in local home mortgages. Although this attempt to grant a special exemption to ERISA's general requirements that trust funds be invested solely for the purpose of providing benefits to plan participants was rejected, further efforts to rationalize the technical treatment of mortgage investment will probably be renewed in 1985.

(D) RELATED ISSUES

Two related issues, though not generating specific legislative initiatives, should be considered in the present context. The actions of the Equal Employment Opportunity Commission [EEOC] proposing to repeal regulations which permit the discontinuation of pension accruals past age 65, as well as the Financial Accounting Standards Board [FASB] proposal to put pension plan liabilities on corporate balance sheets drew the continued attention of congressional policymakers in 1984.

Though the issue of pension accruals after age 65 is discussed in more detail in chapter 4, it is appropriate to mention here the possibility that legislation will be introduced in 1985 to codify EEOC's proposed rulemaking, and thus mandate that employer plan sponsors continue pension accruals for workers chosing to remain actively employed beyond normal retirement age. When enforcement authority over this issue was transferred from the Department of Labor to EEOC in 1978, EEOC acceded to Labor's interpretation of ERISA and the Age Discrimination in Employment Act [ADEA], which permitted the cessation of accruals. EEOC began public hearings on the issue in 1983, culminating in a preliminary repeal of the DOL-originated interpretation.

In 1974, FASB initiated a comprehensive review of pension accounting principles and the impact of ERISA on those professional guidelines. In 1983, FASB released preliminary views, a field test of its proposed changes, intending to bring consistency to pension accounting and to move such disclosures from the footnotes of corporate financial statements directly onto the balance sheet. The project is currently being reevaluated to take into consideration criticisms voiced at public hearings on the proposals.

Any changes eventually implemented by FASB could have a substantial impact on future pension policy. The adoption of preliminary views might effect corporate pension planning, design, and asset mix, as well as the continued growth of final-pay defined benefit pension plans. The exposure of pension liabilities on corporate balance sheets is likely to change the current roll that pensions play in general corporate finance.

3. Prognosis for 1985

Despite all the problems facing the private pension system, it is difficult to escape the conclusion that pensions remain a relatively low priority for Congress as a whole. It is probable that the destiny of pension legislation in the 99th Congress will be driven by external factors. The most likely of these would be a successful tax reform initiative which was not revenue neutral. If substantial revenue is to be raised by restructuring the Tax Code, every tax favored item in the Code will have to rationalize its continued existence, including the current treatment of pension trusts and contributions. Whether the private pension community will take up reform issues on its own, in an attempt to anticipate such scrutiny, remains to be seen.

B. STATE AND LOCAL PUBLIC EMPLOYEE PENSION PLANS

Like the Federal retirement system, State and local pension plans are subject to a vastly different political environment than private plans. Ever since proposition 13 began a wave of State budgetary reform, legislatures have been tempted by spending constraints to forego pension fund contributions in order to meet short-term budget-balancing requirements. On a more positive note, the 1984 elections saw several local and statewide referenda concerning pension issues, including plan investment practices and benefit protections. But at the Federal level, the debate continued to focus on the possible need to extend ERISA preemption of minimum standards to currently excluded State and local plans.

1. Issues

State and local pension plans were intentionally left outside the ambit of ERISA in 1974, despite the fact that many had and still suffer from financing difficulties due to large unfunded liabilities and offer less protection of participants' benefits than federally regulated private plans. Although unions representing State and municipal employees have from the beginning supported the application of ERISA-like standards to these plans, opposition from local officials and interest groups have thus far successfully counteracted these efforts, arguing that the extension of such standards would be an unwarranted—if not unconstitutional—interference with the right of State and local governments to set the terms and conditions of employment for their workers.

This exempted work force is comprised of about 10 million active and 3 million retired participants in over 6,600 plans. Trust fund assets exceed $250 billion and pay benefits amounting to $18 billion annually. Over 80 percent of these plans have fewer than 100 active members, but the largest cover the bulk of active participants: 6 percent of all the plans cover about 95 percent of active membership. Unlike Federal employees, a substantial majority of this work force is covered by Social Security.

Although ERISA exempted Government retirement plans from its major provisions to allow more time to determine whether Federal minimum standards were, in fact, needed, it did authorize the formation of a joint task force by several congressional committees to study a number of benefit security issues. The pension task force report on public employee retirement systems, issued in March 1978 by the House Committee on Education and Labor, concluded that State and local plans were often deficient in several key respects:

Regulatory and statutory confusion.—There is variation and uncertainty in the interpretation and application of provisions pertaining to Government retirement plans, including the antidiscrimination and tax qualification requirements of the Internal Revenue Code.

Participation, vesting, and portability.—Although most plans effectively met ERISA minimum participation and benefit accrual standards, two of every three plans—covering 20 percent of plan participants—did not meet ERISA's minimum vesting standard.

Reporting and disclosure.—Government retirement plans at all levels were frequently not operated in accordance with generally accepted financial and accounting procedures applicable to private plans and other financial enterprises, creating a significant potential for abuse due to the lack of independent and external reviews of operations.

Funding.—Participants, sponsors, and the public were found to be largely unaware of true plan costs because many plans were not funded on the basis of sound actuarial principles and assumptions, resulting in inadequate yearly contributions to fund future benefits.

Benefit reductions or loss.—The greatest risk to benefit security was found to be Government fiscal crises, exacerbated by mismanagement, unexpectly high pension liabilities, and shrinking local tax bases, which in some cases precipitated plan insolvencies and temporary or permanent benefit losses.

Trust fund investment.—There was found to be a general lack of consistent standards of conduct, open opportunities for conflict-in-interest transactions, and frequent poor plan investment performance.

The need for improved standards has not obscured the latent constitutional question posed by Federal regulation, however. In *National League of Cities* v. *Usery,* the U.S. Supreme Court held that extension of Federal minimum wage and maximum hour standards to State and local employees was an unconstitutional interference with State sovereignty reserved under the 10th amendment. Any extention of ERISA standards would be subject to court challenge on similar grounds.

Census Bureau data indicates significant changes in the composition and funding status of State and local plans in recent years.[10] The number of plans has been consolidated, due for the most part to efforts in a few States to bring municipal plans under State control. At the same time, the ratio of active participants has declined from 4.5:1 to 3.5:1 in 5 years. This may be the result of early retirement programs instituted in the face of spending constraints in many States to encourage long service, high salary employees to retire; the lower salary of newly hired replacements, or the reduction in work force size by attrition, can frequently save State and local government significant expenditures.

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[10] Employee Benefit Research Institute. EBRI News. New Five-Year Census Shows Fewer But Better-Funded State and Local Pension Systems. Washington, DC, December 1983, p. 1.

Plan assets and contributions have increased steadily, roughly doubling during the 5-year period, but it is not yet clear whether these positive factors will be sufficient to offset the increased burden of a relatively larger number of retirees in the system. A study of 325 pension funds found that benefit payments on average were increasing faster than total plan contributions, resulting in a net decline in plan contributions.[11] Nor do State and local government have the relatively elastic revenue base available to the Federal Government from which to fund continuing pension liabilities. To some extent, the vulnerability of small, poorly funded municipal plans can be absorbed by larger State pension systems. Whether in the long run these larger systems are healthy enough themselves not to cause statewide fiscal crises is still in doubt for some.

State and local pension plans are exceedingly vulnerable to local politics, though not only from balanced budget referenda as in the recent past. Several cities, including Washington, DC, and San Francisco, witnessed protracted debates over pension fund investment practices in 1984. At issue was the continued investment of pension assets in companies which do business in South Africa: about half of the Fortune 500, favorite blue chip investments for plan trustees. The passage of a local initiative to ban such investments can have serious long- and short-term effects. If a pension fund is forced to divest itself of its holding in a very short period of time, the liquidation of a portfolio at an inopportune time could cost taxpayers millions of dollars in lost asset earnings. Likewise, a wide range of investment opportunities would then be foreclosed, possibly jeopardizing future investment performance.

Critics of such social investment criteria are quick to point out investment boycotts of this type may not be effective in any case, as a market for an attractive investment can almost always be found. Voters who collectively decide to prohibit such investments on moral grounds should be aware that these requirements can have an impact on fiscal planning.

2. Legislative Activity in 1984

Each succeeding Congress seems to bring the introduction or reintroduction of bills designed to extend ERISA-like protections to public pension plans, but invariably they command little consideration outside the House Committee on Education and Labor. So too each year brings the publication of several studies, some less optimistic than others, evaluating the progress made by State and local officials. As the 98th Congress came to a close, the general condition of public plans seemed to have stabilized: there were still identifiable weakness among State and local plans around the country, but too few had reached a crisis stage sufficient to arouse interest in the enactment of Federal minimum standards in Congress as a whole.

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[11] Greenwich Research Associates. Public Pension Funds: 1983 Report to Plan Participants. New York, November 1983.

As in the 97th Congress, two bills—each titled the Public Employees Pension Plan Reporting and Accountability Act of 1984 [PEPPRAA]—were introduced, this time by Representatives Clay and Erlenborn, respectively. In 1982, essentially the same legislation was introduced in both the House and the Senate. Both House bills were reported favorably by the Education and Labor Committee, but the Senate bill languished and was not reported. In 1984, only the House bills were reintroduced; they were again reported favorably but made no further progress.

In brief, H.R. 5143 would require disclosure and reporting of financial information to participants and their representative organizations, Government officials, taxpayers, and the general public; establish fiduciary standards for plan managers and trustees; extend favorable tax treatment to plans meeting these new standards; exempt plans which fulfill the above requirements from having to meet several present conditions for plan qualification under section 401(a) of the Internal Revenue Code, as well as provide an unconditional exemption from Federal income tax under section 501; and make appropriate remedies, sanctions, and access to Federal courts available. The requirements of H.R. 5144 were the same but for the omission of the changes to the IRC. Given past events, it seems likely both House bills will be reintroduced yet again in the 99th Congress, but the degree of their success is no less certain.

3. Prospects for 1985

Resolution of any of these issues is unlikely in the near future. There is little inertia to propel Federal standards to any greater degree of success, though the continuing support of unions, retirees, and taxpayer groups would appear to guarantee the reintroduction of the initiatives expiring this year. State and local governments have consistently opposed Federal action, and critics generally believe that the diversity of plan design and regulation is necessary to meet divergent priorities of different localities and is the strength, not weakness, of what might collectively be referred to as the State and local pension system. Absent unanticipated events shifting this political balance, the only probable changes in 1985—for better or worse—will come from local and not Federal authorities.

C. FEDERAL CIVIL SERVICE RETIREMENT

As pressure on the Congress to close budget deficits increased in 1984, attention continued to focus on the issue of rising entitlement spending. This kept the controversy over the current Federal civil service retirement system alive, a rationalization being sought for what some perceive to be a system which is overly generous and too costly. For the last 2 years, the administration has introduced a proposal which sought to cut benefits and shift some of the Government's cost for the CSRS to employees. They were quickly rejected by the Congress. This exchange will continue to recur, however, until Congress finally completes an overhaul of the system.

1. Issues

CSRS covers approximately 2.7 million Federal civilian workers and pays benefits to 1.3 million retirees and 500,000 survivor annuitants. Rapidly rising outlays have prompted past reductions in the program. In 1976, Congress began the process of eliminating aspects of the CSRS cost-of-living adjustment mechanism which were causing the most substantial increases in benefits. Serious proposals continue to be voiced to further reduce annual increases. CSRS has become a deficit reduction target due to its size and the potential savings that could be generated from a substantial reduction in the federally paid portion of benefits.

Enactment of Social Security coverage for new Federal employees in the Social Security Amendments of 1983 touched off a period of significant change for the Federal civil service retirement system which will continue through the 99th Congress. Social Security coverage itself created both a need to restructure Federal pensions for new employees and an opportunity for the Congress to reexamine the overall structure of Federal employee compensation. Congressional committees charged with the task of designing a new pension plan initiated a lengthy study process, deferring the introduction of legislation until 1985. But to meet the needs of employees hired in the interim, the Congress enacted a bill at the end of 1983 to provide temporary pension coverage.

(A) COST

Substantial criticism has been directed at the cost to the Government of financing the CSRS program. The annual outlays are large and growing, with the Government's share of this cost growing as well. Total payments from the CSRS trust fund have tripled, in current dollars, over the last decade. At the same time, the proportion of this cost paid by the Government has increased from 65 percent in 1975 to an estimate in excess of 80 percent in 1985.

Whether or not CSRS costs are excessive depends upon how they compare on a per-participant basis to the cost other employers bear for comparable plans, and how large a portion of the Government's resources are consumed in this activity. Compared to the per-participant cost of most private pension plans, civil service retirement costs seem high. The average large private pension plan, when combined with Social Security, has been estimated to cost an employer 20 to 23 percent of payroll. Even though Federal employees contribute 7 percent of pay themselves to the CSRS, the Federal Government's payments amount to an additional 30 percent of payroll, nearly 50 percent more than the private sector average.[12]

Two features of CSRS contribute to its higher operating costs compared to the average private pension plan: full cost-of-living adjustments [COLA's] for benefits after retirement, and early retirement with full benefits at age 55—with sufficient years of service.

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[12] U.S. Congressional Budget Office. Civil Service Retirement: Financing and Costs. Washington, U.S. Govt. Print. Off., 1981, p. 16.

Private pension plans usually make cost-of-living adjustments on an ad hoc basis, limited to 3 or 4 percent a year; only Social Security benefits are fully indexed. Additionally, full private pension and Social Security benefits are generally available only at age 55 and are reduced if taken at an earlier age. Perhaps half of the cost differential can be attributed to these features. A Congressional Research Service [CRS] study completed in 1982 indicated that full COLA's and retirement at age 55 alone cost the CSRS 5 percent of payroll.

(B) BENEFIT ADEQUACY

The public often assumes the civil service retirement system costs relatively more to operate than a private retirement program because it provides substantially better protection to Federal employees. Some critics have gone so far as to argue that it provides excessive retirement benefits. However, there is increasing concern among experts that the CSRS, in fact, provides inadequate benefits to a portion of the Federal work force.

The program, like many employer-provided defined benefit pension plans, tilts its compensation to reward long service and later employment termination, and provides proportionately high compensation to highly paid workers. Social Security, by contrast, provides a basic retirement income to all employees, tilts its benefits to provide higher proportional compensation to lower paid workers, and does not penalize workers for job mobility or early termination. Workers covered by Social Security plus an employer-provided retirement plan—which is not fully integrated with the Social Security benefit—can gain from the contrasting advantages of each. However, Federal workers covered by CSRS only may receive inadequate benefits because they are not covered by Social Security.

Full career employees are usually well rewarded by CSRS for their long years of service, but their benefit comes at the expense of more mobile employees. This inadequacy stems, in large part, from the lack of portability of Federal pension benefits. Employees must work 5 years to become vested in benefits and must work 10 years before the benefit formula begins crediting at full rates. Those who leave after vesting may choose to withdraw their own contributions instead of qualifying for benefits, but if they do, they forego the value of the Government's share. If their contributions are left in the system, they can receive retirement benefits, but the amount of the benefits will be fixed in relation to their salary at the time they left Federal service.

These limitations frequently cause Federal employees who spend less than a full career in Federal service to receive little retirement income of value for their years of service with the Government. OPM estimated that 62 percent of all Federal employees coming into the civil service retirement system will receive no Federal pension benefits. In all, two-thirds of the benefits paid will go to only one-fourth of the Federal employees. This would be a less serious problem if those who left Federal service early received indexed or transferable credits for their years of service. But lack of Social Security coverage effectively denies them portable retirement benefits they would otherwise have received in the private sector.

(C) SUPPLEMENTAL PLAN DESIGN

The most significant development for the civil service retirement system in several years was the enactment of Social Security coverage for new Federal employees, Members of Congress, and others in the executive and judicial branch in 1983. Social Security coverage for Federal workers had long been proposed by pension experts as a way to improve their retirement income while simultaneously improving the financial condition of the Social Security trust funds. Popular opposition was also growing to the exclusion of Federal workers from a social insurance system that was compulsory for others.

Under the Social Security Amendments of 1983, signed into law by President Reagan as Public Law 98-21, coverage was extended to the following groups of Federal employees, effective January 1, 1984:

(1) All Federal employees hired or rehired after a break in service exceeding 365 days on or after January 1, 1984; including executive, judicial, and legislative branch employees.

(2) Current legislative branch employees not participating in the CSRS on December 31, 1983.

(3) All Members of Congress, the President, the Vice President, executive level political appointees, and Federal judges, including retired Federal judges resuming judicial duties.

Enactment of Social Security coverage brought about the immediate need to repeal the mandatory participation of new Federal employees in the civil service retirement system, lest the Federal Government be required by statute to withhold 13.7 percent from the pay of employees hired in 1984—6.7 percent for Social Security and 7 percent for CSRS.

Just before the end of the first session, the Congress agreed to an interim civil service retirement plan for new employees to resolve the double withholding problem. The interim plan was designed to give supplemental coverage for new employees under the CSRS while maintaining an equitable rate of withholding between new and current workers. Federal employees hired on or after January 1, 1984, have 1.3 percent of pay withheld for the CSRS, in addition to the 7 percent withheld for Social Security including Medicare. Total withholding of 8.3 percent for new employees will equal the withholding of 7 percent for CSRS and 1.3 percent for Medicare for current workers. But coverage expires on December 31, 1985, at which time double withholding will resume unless a supplemental plan has been enacted.

(D) ADMINISTRATION PROPOSALS FOR COST-CUTTING

Because cost-of-living adjustments [COLA's] are the most expensive feature of the CSRS, during the last decade they have become a prime target of cost-cutting efforts. This trend began in 1976, and in each of the last 4 years Congress has included further changes in Federal civil service retirement COLA's in the annual budget reconciliation act. However, the administration's proposals to limit the growing cost of CSRS have not been limited to COLA reductions or delays. In 1983, the Reagan administration included in the fiscal year 1984 budget a proposal to cancel the May 1984 COLA and extend beyond 1985 the payment of partial COLA's to Federal retirees under age 62, along with a more controversial budget proposal to restructure the CSRS. Although the budget package was rejected by Congress in 1983 and again in 1984, CSRS may again be targeted for change by the administration in its fiscal year 1986 proposal.

At the time of this writing, the administration plan was expected to resemble previous recommendations, and will probably contain some or all of the following provisions:

(1) Full COLA's would only be given for pension benefits up to a particular level, perhaps $10,000. Any pension in excess of this threshhold would only get approximately half the increase in the cost of living.

(2) Employee contributions to fund the benefits would be increased from 7 percent of compensation to 9 percent.

(3) Future retiree benefits would be calculated as the average of the highest 5 years of compensation rather than the highest 3, as currently calculated.

(4) A phased-in reduction of benefits for retirement prior to age 65, 5 percent for each year prior to the normal retirement age. The phase-in would be based on age cohorts of current employees. Those now 55 or over would be unaffected. Those retiring at 55 would have their pension reduced by 25 percent. Employees now 45 or under would be subject to the full 5 percent per year reduction.

If ever implemented, these proposals would have a significant impact not only on the cost of CSRS to each employee but on the adequacy of benefits as well. The $10,000 threshhold would significantly reduce COLA increases for benefits above this level, but introduce substantial inequities by failing to distinguish between benefit levels on the basis of length of service. For example, a career Federal employee who receives a CSRS benefit of $15,000 a year would suffer a 17-percent decrease in yearly COLA adjustments. However, a short term but highly compensated Federal employee, receiving both substantial Social Security and pension benefits from employment in the private sector, could receive an additional $10,000 from CSRS with full COLA adjustments. If the primary purpose of the current structure of CSRS—which provides higher benefits for long-term employment—is to encourage career service in Federal employment, it makes no sense to enact an ostensible cost-saving devise which penalizes career Federal employees.

2. LEGISLATIVE ACTIVITY IN 1984

Given the large task facing Congress when it finally takes up the challenge of redesigning CSRS, 1984 was not surprisingly a rather slow year for enactments. As part of the general movement toward spousal equity in pension plans,[13] Congress passed the Civil Service Spouse Retirement Equity Act [Public Law 98-615] on November 8. Under the act's provisions, a participant in CSRS who is vested cannot waive his or her right to a benefit in the form of a joint and survivor annuity without the spouse's consent. It further provides for the treatment of survivor annuities for former spouses.

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[13] See discussion of the Retirement Equity Act, pp. 53-54.

In this way, the likelihood that the spouse of a Federal employee will lose entitlement to the partner's pension benefit due to the partner's death should be reduced.

(A) COLA'S

The seemingly constant readjustment of Federal COLA's continued in 1984 during the fiscal year 1985 budget reconciliation process. After considerable debate, on April 5, the Senate adopted a version of the budget resolution that eliminated remaining 1-month delays in COLA's scheduled for fiscal years 1984 and 1985, and replaced those delays with a single 7-month delay. Instead of occurring in May 1984—payable in June checks—the next adjustment was rescheduled for December 1984—payable in January. The cycle is now permanent and will be repeated annually based on a comparison of CPI change between third quarter averages since the prior year's COLA. The Budget Reconciliation Act [Public Law 98-270] also retained the schedule of adjustments for retirees under age 62.

The Omnibus Deficit Reduction Act of 1984 [Public Law 98-369] removed the offset to civilian salaries of military retirement COLA's for former military personnel now employed by the Federal Government. The offset had reduced salaries dollar-for-dollar for any COLA applied to military retirement annuities received by such workers. The act also preserved the scheduled expiration of the so-called diet COLA—the reduction in adjustments for Federal retirees under 62 years of age—in fiscal year 1985. Thus, COLA's for Federal retirees under age 62 will now return to the full adjustments received by retirees over that age. This change was then clarified in a supplemental appropriations bill, Public Law 98-396, to correct a discrepancy which arose when estimated CPI increases were substantially less than earlier assumed inflation rates.

(B) CSRS REFORM

Three major reform initiatives have emerged from Congress since 1982. Each takes a somewhat different approach to reforming the system. The first, S. 2905, was introduced by Senator Stevens, and was followed in 1983 by a three-bill package—H.R. 3751, H.R. 3752, and H.R. 3753—collectively referred to as the Federal Annuity and Investment Reform [FAIR] program by its sponsor, Representative Erlenborn. At the very close of 1984, Senator Stevens introduced his second proposal, which moved in the direction of the Erlenborn initiatives but retained many distinct features. This concluding section will consider the issues raised by the differences between these proposals.

Senator Stevens' 1982 initiative, S. 2905, would have mandatorially included new Federal and postal workers hired after the date of enactment and permitted employees hired before that date to opt into the program. It would provide a three-tier system, comparable to retirement arrangements often found in the private sector, based on Social Security, a contributory defined contribution plan, and a voluntary thrift plan. Employees would have vested in the plan after 5 years, allowing them to leave with the entire amount of their account after a 5-year tenure. Representative Erlenborn's

FAIR package also provided for a three-tier system, but the second element consisted of a defined benefit plan and also included a COLA reduction for benefits above $10,000.

The original proposal contained in S. 2905 presented several advantages for short-service Federal employees. After 5 years' tenure they would be able to take portable benefits not only from Social Security but from the defined contribution and thrift plans as well. The current CSRS is subject to the political risk that future Congresses will meet the financial obligations of future benefit payments. This alternative transforms some of that risk from a political to a financial risk that the investment return of the defined contribution plan will keep pace with inflation. This increased exposure to financial risks might have been to the disadvantage of career employees, however, so Senator Stevens determined not to pursue passage of this initiative until a majority of those who would be effected by the proposal supported it.

Senator Stevens announced the details of a new proposal in December 1984. It too is a three-tier approach based on Social Security, but with a second tier supplemental defined-benefit plan—with a 2-percent reduction in annuity payments for each year of retirement before age 62—designed to provide somewhat smaller benefits than the second tier of the FAIR proposal. Likewise, the third tier of thrift savings is transformed into a section 401(k) salary reduction mechanism in which employees could defer up to 16 percent of their salary into the plan. The Government would match the first 4 percent of these contributions on a $2-to-$1 basis.

The reception this new approach will receive remains uncertain. Compared to S. 2905, it lessens the financial risk to career employees. The administration has as an explicit stated goal an increase in the share of retirement benefits funded out of employee contributions. Assuming the 401(k) salary reduction feature is utilized to defer an average of 4 percent of salary—a common amount in the private sector—the total employee contribution to the retirement program, including Social Security payroll taxes, would be approximately 11 percent of salary compared to the present 8.3 percent. At the same time short-term employees would experience an increased portability in their benefit accruals. As a whole, the proposal raises many interesting political and policy questions, and should be a focus of discussion and debate in 1985.

3. PROSPECTS FOR 1985

The timetable set up by the compromise interim coverage plan for new Federal employees will produce proposed permanent replacements for the interim plan in 1985, but the likelihood that Congress will complete consideration of the issue without being forced to extend the temporary plan into 1986 is less certain. Despite budget pressures, it makes little sense to restructure the program for Federal workers covered under the old system until the new one is put into place. At this time, additional study and substantial interest group support for new alternatives need to be developed. Proposals to simply cut COLA's or other benefits under the old system are unlikely to be given serious consideration in the near future.

D. MILITARY RETIREMENT

Like Federal civil service retirement, military retirement has become a deficit reduction target in the search for ways to reduce Federal spending. In spite of the debate over the benefits available to retired military personnel, the program has remained almost entirely intact due to the vocal representation of a politically indentifiable constituency.

1. ISSUES

The military retirement system has been highlighted by numerous commissions and the media as one of the principal programs aggravating the Federal budget deficit. In this instance, escalating costs are compounded by the specter of servicemen in their forties retiring at 50 percent of basic pay some 15 or 20 years before their counterparts in the private sector. The temptation to compare military pensions to those found in the private sector solely on the basis of economic factors is difficult to avoid, especially absent any immediate threat of war. For many military retirement appears to be synonymous with retirement to another job.

(A) THE ROLE OF MILITARY RETIREMENT IN ARMED SERVICES COMPENSATION POLICY

Concern over expenditures for military retirement has been fueled by rapidly rising costs and what some perceive to be overly generous benefits. Approximately 1.3 million retired officers, enlisted personnel, and their beneficiaries received more than $16 billion in annuity payments. At current rates of growth, the expenditure is expected to reach $45 billion by the turn of the century. Since 1969, 10 separate studies have recommended changes to reduce the system's cost, but no comprehensive legislation has resulted. In particular, the availability of retirement benefits at 50 percent of active pay after 20 years of service regardless of age has been cited as a costly plan component that no longer serves a useful manpower management purpose. Nevertheless, recent cost-savings in the military retirement system have generally been limited to COLA delays and modifications commensurate with those affecting civilian Federal employees, such as the 7-month delay for the May 1984 COLA and reestablishment of the COLA updating cycle to December 1984.

Supporters of the current military retirement scheme have identified several special characteristics arguably unique to military life which they feel justifies this treatment. All retired personnel are subject to involuntary recall in the event of a national emergency; retirement pay is ostensibly part compensation for this exigency. Military service is also seen to place special demands on military personnel, including higher levels of stress and danger, than employment in the civilian work force. Finally, the current benefit structure provides a significant incentive for older personnel to leave the service: Almost 90 percent of military retirees are under age 65. Some view this as necessary to maintain the youth and vigor of the armed services.

One administrative change included in the 1983 Defense Authorization Act, Public Law 98–94, could have an impact on future spending decisions in Congress. In the past, military retirement was paid out of general operating funds, so that the amount allocated each year represented the cost of current annuity payments to retirees. Under a newly implemented accrual accounting method, allocations in the Department of Defense budget reflect the present cost of funding future benefits for active military personnel and are paid from the same retirement account as the civil service retirement system. The change does not increase the liability which must be born by Federal taxpayers, but it does make explicit in the budget recognized future liabilities. Although this type of accounting is volatile with respect to future age, price, interest, and personnel assumption, it should give Congress a more realistic perspective on the present and future fiscal consequencs of the program.

(B) CRITICISMS OF THE CURRENT PROGRAM

The characteristics of the military retirement system are in several resects unique in Federal pension policy. These differences, especially the 20-year retirement provisions of the program, have become a focal point for criticism and debate.

(1) Twenty-Year Retirement

Of the 10 studies criticizing military retirment, none has suggested that members of the Armed Forces should not be entitled to some retirement benefit after 20 years. In fact, several have found the requirement of 20 years of service as an unreasonably long time to acquire entitlement to a pension. It far exceeds the vesting requirement in the CSRS and the minimum vesting standard applicable to private pension plans and does not appear to have positive effect on work force composition.

The failure to design military retirement in an manner analogous to pensions in other work forces has potentially detrimental consequences for both the composition of the armed services personnel and the costs of the program to taxpayers. The availability of pension benefits only after 20 years' service is likely to prolong the careers of marginal military personnel beyond their usefulness. Simultaneously, the unreduced benefit provides a significant incentive for highly skilled and experienced personnel, with years of technical training, to leave the Armed Forces for second careers as soon as the 20 years are complete. The combination of all these effects is a system which pays benefits to a disproportionately high number of officers compared to the composition of the armed services personnel as a whole.

The scrutiny of cost-effectiveness and equity in the military retirement system has led the majority of studies to recommend accelerated vesting, most often to 10 years. Similarly, reductions for benefits collected for retirement prior to 62 have also been suggested. Under the current program, nearly 65 percent of officers and 90 percent of enlisted personnel leave before completing 20 years of service. The 20-year requirement, far from an incentive to continued service, appears to be little more than a penalty for return to civilian employment.

(2) Retirement Funding Contributions by Military Personnel

Military personnel do not contribute to their retirement benefits, though they do pay Social Security taxes and offset a certain amount of their pay to participate in the Survivor Benefit Program. Only a small minority of the studies previously mentioned recommended contributions by individuals. This has two consequences: For employees, they have no employee contributions to take with them if they leave before vesting in a retirement benefit, as do Federal employees participating in CSRS; for the taxpayer, a small but significant source of revenue to fund the program is forgone.

(3) Integration with Social Security

Since the institution of Social Security coverage for military personnel in 1956, military retirement benefits have been paid without any offset for Social Security receipt. Taking into account the frequency with which military personnel in their middle forties retire after 20 years' service, it is not unusual to find them retiring from their second career with a pension from their private sector employer along with their military pension and Social Security benefits. This has resulted in some former armed services personnel receiving an overreplacement of preretirement income. Failure to integrate military retirement benefits with Social Security generally adds to the perception that it is an overly generous system, even though only the minority of military personnel ever receive a pension for their military service.

2. Legislative Activity

The cycle of appropriations, budget reconciliation, and deficit reduction bills produced two principal changes in military retirement in 1984. The Budget Reconciliation Act [Public Law 98-270] placed military retirement COLA's back on a 12-month cycle after delaying the May 1984 COLA to December 1984. The Deficit Reduction Act [Public Law 98-369] maintained the scheduled fiscal year 1985 expiration of the so-called diet COLA for Federal and military retirees under age 62. Opponents of this half COLA had maintained that its effect was disproportionately harsh for military retirees, who draw pension benefits over an extremely extended period of time. All Federal and military retirees will now receive comparable COLA treatment with no distinction on the basis of age. DEFRA also repealed the remaining offset—dollar for dollar for any COLA to a military retirement annuity—to salaries of retired members of the armed services employed by the civilian government.

3. Prospects for 1985

Like civil service retirement reform, any changes to the system must overcome a vast amount of inertia and the well organized opposition of constituencies which do not favor change. Hence, a successful attempt to cut Federal expenditures by redesigning military retirement is improbable in isolation from broad-based Federal spending cuts. At this time it appears more likely military retirement will be subject to a temporary freeze on its growth, along with other Federal programs, than a far-reaching reconstruction.

E. RAILROAD RETIREMENT SYSTEM

The railroad retirement system is a federally managed retirement system covering employees in the rail industry, with benefits and financing coordinated with the Social Security System. The system was authorized in 1935, prior to the creation of Social Security, and it remains the only federally administered pension program for a private industry. It covers hundreds of railroad firms and distributes age and disability benefits to retired employees, their spouses, and survivors. Benefits are financed through a combination of employee and employer payments to a trust fund, with the exception of dual vested or so-called windfall benefits, which are paid for through Federal general revenues from a special account. Currently, just under 1 million retirees receive railroad retirement benefits, and total payments to these beneficiaries are anticipated to reach almost $6 billion in fiscal year 1985. Rail employment, which determines the financial status of the railroad retirement system through payroll tax revenues, has stabilized at a level hovering around 400,000, after dropping precipitously in 1981, 1982, and early 1983.

1. Issues

(A) THE STRUCTURE OF THE RAILROAD RETIREMENT SYSTEM

The broadest policy issue associated with the railroad retirement system is whether an independent publicly administered railroad pension system is still necessary. The general structure of the railroad retirement system is a result of its unique evolution. In order to understand the major issues facing the railroad retirement system, it is critical to review its unique development. In the final quarter of the 19th century, railroad companies were among the largest in America, and were marked by a high degree of organizational centralization and integration. The original railroad retirement system was enacted in 1934 to provide annuities to retirees based on rail earnings and length of service.

The Railroad Retirement Act of 1974 fundamentally reorganized the railroad retirement system, and established the outline of its present day organization. Most significantly, the legislation created a two-tier benefit structure in which tier I serves as an equivalent to Social Security, and tier II parallels a private pension. Tier I benefits are computed on credits earned in both rail and nonrail work, while tier II is based solely on railroad employment. The total benefit amounts to traditional railroad annuities, and eliminates duplicate coverage for nonrail service by both Social Security and the railroad retirement system. In its fiscal year 1983 budget, the Reagan administration proposed dismantling the system, with Social Security absorbing tier I, and tier II being converted into a private pension, administered by a private corporation. This proposal was founded on the assumption that the Government should not administer an industry pension, and that given the equivalency of tier I and Social Security, it is appropriate to combine the two, and create a privately administered pension to complement it, as is the case with other industries.

This proposal was rejected by Congress. Many felt that reorganization would lead to a cut in benefits for present and future retirees, and that if exempted from ERISA standards, as proposed by the administration, employees and retirees would have no guarantee that their full pensions would be provided. It was further argued that such a conversion would exacerbate Social Security's financing problems, and create administrative difficulties for SSA.

(B) FINANCING PROBLEMS

The 1970's were years of poor performance in the rail industry, and by 1980, the retirement trust fund was faced with the prospect of insolvency. Declining rail traffic, and hence declining employment, led to diminished payroll tax revenues. Since the end of World War II, the worker/beneficiary ratio has been decreasing, as described by the table below:

EMPLOYEES IN THE RAILROAD INDUSTRY AND BENEFICIARIES OF THE RAILROAD RETIREMENT SYSTEM SINCE 1945

[In thousands]

	Average employment	Beneficiaries
Year:		
1945	1,689	210
1950	1,421	461
1955	1,239	704
1960	909	883
1965	753	930
1970	640	1,052
1975	548	1,094
1976	540	1,100
1977	545	1,107
1978	542	1,100
1979	554	1,093
1980	532	1,084
1981	503	999
1982	440	988
1983	390	981
1984	400	980

Source: Railroad Retirement Board, 1984.

This longer term financing problem was aggravated by the fact that congressional appropriations for windfall benefits were far from sufficient to pay for those benefits, and the difference was paid from the railroad retirement trust fund.

To improve the system's financial condition, Congress included railroad retirement provisions in both the Omnibus Budget Reconciliation Act of 1981 [Public Law 97-35] and the Economic Recovery Tax Act of 1981 [Public Law 97-34]. These amendments raised payroll taxes on employers and employees, modified benefits, created a separate account for windfall benefits, and provided the railroad retirement trust fund with authority to borrow funds from the General Treasury, when near term cash-flow difficulties arise.

Unfortunately, the recession devastated the railroad industry in the final quarter of 1982, bringing the railroad retirement system once again to the brink of insolvency.

Early in 1983, rail labor and management collectively negotiated a comprehensive financing package and submitted it to Congress. This agreement was considered by Congress, revised, and ultimately enacted in August 1983. The final package was composed of payroll tax increases, benefit reductions, and Federal contributions. Passage averted a 40-percent reduction in tier II benefits scheduled for October 1, 1983.

The most significant benefit change was the COLA offset provision, which required that the next 5 percent of tier I—Social Security—COLA increases be subtracted, dollar for dollar, from tier II—railroad pension—benefits.

In addition, the so-called 60-30 benefit, which allowed employees with 30 years of service to retire at age 60 without benefit reduction, was scheduled to be phased out.

Three annual 0.75 percent railroad retirement payroll tax increases—the first went into effect in January 1984—were levied on rail employees and employers.

The railroad unemployment insurance tax paid by employers will be levied on the first $600 of monthly earnings, which is 50-percent higher than the previous $400 wage base. On July 1, 1986, a temporary unemployment tax will be collected from employers to repay a debt by the unemployment account to the retirement fund.

Tier II benefits and vested dual or windfall benefits were made subject to Federal income taxation under the same guidelines as private pension earnings, that is, to the extent the pension income exceeds the employee's contributions. The revenues collected from this taxation will be transferred to the rail trust fund to finance benefits payments, through 1989. After that point, the revenues will remain with the Federal Treasury.

Overall, the Railroad Retirement Solvency Act of 1983, through a combination of tax increases, benefit adjustments, and Federal assistance should guarantee the solvency of the railroad retirement system through the 1990's, even under pessimistic employment assumptions. Further, it is expected that in the future, the worker/retiree ratio will increase, as the peak in the number of retirees passes.

The legislation is not without its critics though, and it is important to point out some of the weaknesses in the law. For instance, the COLA offset provision could not be accomplished if the tier II benefit component were truly an industry pension, and subject to ERISA regulations. To take funds from tier II to offset increases in tier I benefits partially undermines the basic assumption of the 1974 reorganization. The abrupt phaseout of 60-30 benefits jeopardizes the plans of older rail employees who had conceived their retirement on benefit assumptions that have been rendered invalid. To change the rules midstream, and with such rapidity, is inequitable to employees nearing retirement. Finally, the tax treatment of windfall benefits as equivalent to pension benefits is inconsistent with the fact that windfall payments accrue from Social Security coverage. Windfall benefits should be taxed like Social Security benefits, not like returns from a private pension.

2. LEGISLATIVE ACTIVITY

The railroad retirement system was the subject of very little congressional attention during 1984. Following the passage of the Railroad Retirement Solvency Act of 1983 [Public Law 98-76] which restored short and long-term solvency to the railroad retirement system through a combination of tax increases, benefit reductions, and Federal financing, there was little impetus for major legislative action in 1984. One subject left unresolved by the comprehensive legislative package enacted in 1983, however, is the insolvency of the Railroad Unemployment Insurance [RUI] Program. The 1983 legislation did establish a railroad unemployment compensation [RUC] committee, composed of representatives of rail labor, management, and the general public, to examine the condition of the RUI Program, and make recommendations to Congress to redress the system's financial crisis. The RUC made its report on June 29, 1984, and Congress will consider RUI legislation in 1985.

3. PROGNOSIS

The Railroad Unemployment Insurance [RUI] system is insolvent, and has borrowed money to pay benefits from the retirement system for 19 of the last 24 years. In the past, these loans were used to bridge short-term cash-flow problems in the RUI Program, and were repaid with interest. However, drastic increases in rail unemployment in the past few years has led to more protracted and more extensive borrowing from the retirement fund. By July 1984, the RUI system owed more than $700 million to the retirement account. It is expected this debt will reach $1 billion in fiscal year 1986. Without major changes in the financing of the RUI system, it is unlikely that this debt could ever be serviced.

The 1983 retirement solvency act eliminates the unemployment system's authority to borrow from the retirement fund, effective September 30, 1985. Before this deadline is reached, Congress must financially rescue or restructure the RUI Program; otherwise the system's insolvency will prevent the payment of benefits to unemployed rail workers. To assist Congress is responding to this upcoming crisis, the 1983 legislation created a railroad unemployment compensation [RUC] committee to study the RUI problem and make recommendations to Congress to either restore solvency to the RUI system or to fold it into the Federal-State unemployment compensation system.

The RUC panel presented two alternative proposals in its June 29, 1984, report. A majority of this panel, consisting of the two labor members and the chairman, recommended keeping a separate rail unemployment insurance system. The two management members advocated a transfer of the RUI system to the States, and provided a proposal to accomplish this in a fashion acceptable to rail companies. The management representatives joined the majority in shaping a consensus package of specific recommendations for saving the RUI system. If Congress rejects the management proposal to transfer the RUI system to the States, then management would support the consensus package as a reasonable alternative.

Under the consensus package, a separate RUI system would be retained and solvency would be restored through a number of financing changes. From the standpoint of the retirement fund, the most critical provision in the consensus proposal is a waiver of all interest on $1 billion of debt owed to the retirement account. This provision pits the interests of younger employees, faced with the prospect of continued spells of high unemployment, against the concerns of retirees.

The principal on the RUI loans would be repaid through a flat-rate tax imposed on railroad companies. Additionally, a variable employer-paid surcharge tax would be levied with rates depending upon the balence in the RUI account. General revenues would contribute to the rescue of the RUI system through a one-time grant of $135 million and the RUI account would be provided with the authority to borrow from the Treasury to avoid near-term cash-flow problems. Finally, the consenus proposal recommends certain tax and benefit modifications to improve the financial health of the RUI system.

The management proposal recommends a transfer of the RUI system to the States at the beginning of the first benefit year—which begins July 1—feasible after enactment. Rail carriers would begin paying State unemployment taxes, and in addition, a surcharge tax would be levied to pay back the principal on the debt owed to the retirement fund, but not the interest. Sickness benefits, an important feature of the RUI system, would be established as a separate program administered by the RRB, and financed through a small tax on carriers. The Federal Government under this plan would transfer $200 million to the retirement account to compensate for interest paid on loans while States were receiving interest-free loans. General revenue funds would also be provided to States to help with the transition between the two systems, when unemployed rail workers would be receiving benefits that would be partially based on untaxed compensation.

Independent of the RUC committee, the Reagan administration has proposed its own legislative package that would transfer the RUI system to the State unemployment compensation programs. This proposal was introduced by request in the House by Representative Conable on August 2, 1984, as H.R. 6068. This plan would have required newly unemployed rail workers to begin filing for State benefits on January 1, 1986; continuing RUI beneficiaries would have had their claims converted by June 30, 1986. Railroad employers would reimburse the States for all benefits paid to rail workers between January 1, 1985, and June 30, 1986. The RUI system would be allowed to continue to borrow from the retirement fund until June 30, 1986, and the debt to the retirement system would be serviced through the special unemployment surtax mandated by the 1983 solvency legislation.

As a matter of railroad retirement policy, the critical issue is how will the enormous debt owed by the RUI system be paid, and more specifically, will the retirement account recoup the interest owed on that debt over time.

Chapter 3

TAXES AND SAVINGS

OVERVIEW

Older Americans have benefited from special tax advantages since tax-free Social Security benefits were first paid in 1940. The exclusion of Social Security income and other tax advantages enacted subsequently were intended to extend the purchasing power of the limited cash resources the elderly received. Now, however, support for some of these tax advantages may be weakening in light of efforts to raise tax revenues to reduce Federal budget deficits. Proposals to reform the tax structure to increase tax equity, and a belief by some that the elderly as a group are no longer in as great need of special treatment as they once were, are signs that certain tax advantages for the elderly may be in jeopardy.

The first concrete signs of a change in attitude about special tax provisions for the elderly appeared with the enactment of the Social Security Amendments of 1983. As part of a package of changes to solve Social Security financing problems, the 1983 amendments made Social Security and railroad retirement benefits taxable for the first time—generally taxing half of the benefit for those who have substantial income from other sources. The 1983 amendments also eliminated a special tax credit previously available to retired public employees younger than 65 years of age. The most significant effect of the change was to increase tax liability by as much as 2 percent of income for the 10 percent of the elderly taxpayers with the highest incomes.

Legislation in recent years to raise Federal revenues and improve tax equity through broadening of the tax base and greater taxpayer compliance has also changed the way the elderly pay some of their taxes. In the Tax Equity and Fiscal Responsibility Act of 1982, the Congress reduced the obligation to estimate and pay quarterly taxes on pension and interest income by requiring payers of pension annuities and interest to withhold taxes. While pension withholding has remained in effect, public pressure forced the repeal of withholding on interest and dividend income in 1983. This year, as part of the Deficit Reduction Act of 1984 [DEFRA), the Congress provided the Secretary of the Treasury with greater discretion to waive penalties for elderly and other taxpayers who, through ignorance of the requirement, fail to file estimated quarterly tax payments.

The growing concern over the complexity of the tax law and over tax equity led to the introduction of a number of tax reform bills in the 98th Congress to institute a flat tax rate or modified flat tax rate with fewer deductions and exemptions. Some of these proposals would eliminate one or more special exemptions or deductions for the elderly. Most, however, would leave the Social Security exemption and other special provisions in place. All of the proposals would change marginal tax rates and affect the total tax payments of individuals.

Although widespread changes in the tax system are now being proposed, to date the only substantial change in the special treatment of income for those 65 and over has occurred as a result of the taxation of Social Security and railroad retirement benefits beginning with the 1984 tax year. With growing budget pressures, however, additional tax changes are likely in the near future.

The changing attitude toward tax advantages for the elderly has been accompanied by a shift in Federal policy concerning savings and investment. As part of a national strategy to increase capital available for investment, tax incentives for corporate and personal savings were expanded by the Economic Recovery Tax Act of 1981. Although some analysts have suggested that increased receipt of asset income would improve retirement income adequacy, most of these incentives were not retirement specific; consideration of income adequacy needs was probably secondary to Congress' desire to pursue national investment goals when ERTA expanded individual retirement account [IRA] eligibility.

The rapid expansion of tax-favored savings vehicles between 1974 and 1981 has slowed significantly as Congress sought ways to check erosion of the Federal tax base in the face of recent Federal budget deficits. Employer-sponsored capital accumulation plans received the same broad scrutiny applied to employer-provided fringe benefits. DEFRA strengthened nondiscrimination tests applicable to employer-sponsored cash-or-deferred savings plans in an effort to prevent their use primarily as tax shelters for high-income employees. Despite these concerns, however, new incentives for employee stock ownership plans [ESOP's] were created, and interest in increased IRA contribution limits continued in both Congress and the administration.

In addition to budgetary constraints on the continued growth of tax incentives for savings and asset accumulation, questions have been raised about their ability to increase net national savings or asset income in retirement. There is some concern that tax-favored treatment simply causes individuals to shift aftertax savings into tax-deferred vehicles. It is unclear, however, whether Congress will focus on these issues during the 99th Congress or have its attention drawn to the broader issue of tax reform generally.

A. TAXES

Concern about the special tax treatment accorded those 65 and older tends to focus on whether these provisions are equitable and whether they still serve a worthwhile purpose. Four tax provisions are of benefit exclusively to older persons and others who receive Federal benefits: The exclusion of Social Security and railroad retirement benefits if their adjusted gross income is below $25,000 for single filers and $32,000 for joint filers, and the exclusion of veteran's benefits; the additional exemption for persons 65 and older; the 15-percent elderly tax credit for disabled and elderly persons with limited incomes; and the one-time exclusion of capital gain from the sale of a home after age 55. In addition, the elderly benefit from tax provisions that are not age specific, such as medical expense deductions, State and local bond interest exclusion, and deductions for charitable contributions.

Social Security, railroad retirement, and veterans benefits prior to 1983 were, like many other Government transfer payments, exempt from taxation. The original Social Security legislation made no specific reference to the tax treatment of benefits. However, a revenue ruling was issued at the time benefits were first paid, stating: That Congress did not intend for Social Security benefits to be taxed since it did not include a provision to tax them in the law, and that the benefits were intended as gratuities and not earnings-related annuities, and therefore were not taxable. In 1983, the Congress included in the legislation to restore financial solvency to Social Security a provision to tax half of the Social Security and railroad retirement benefits of those whose combined income exceeded $25,000 for single filers and $32,000 for joint filers. The rationale for this change was to place the tax treatment of Social Security and railroad retirement on a similar basis to that of employer-sponsored pensions by excluding from taxation only the portion of the benefit attributable to employee contributions. The limit on taxability was justified as a means of protecting low- and moderate-income beneficiaries from a sudden increase in tax payments. Taxation of benefits will phase in gradually for those whose incomes are now below the fixed limits because, over time, their incomes will rise as the limits remain the same.

The extra personal exemption for taxpayers 65 and older was added to the Tax Code in the Revenue Act of 1948 to compensate for perceived economic handicaps of the elderly and to provide some relief from the effects of the postwar economy. Congress viewed a general exemption as the best response to the particularly high concentration of low incomes among the elderly and the severe effects on their incomes of price and tax increases during the war and price increases after the war. The elderly were provided special treatment because they could not benefit from the rapid wage gains being realized by workers in the postwar economy. At the time it was enacted, the extra personal exemption was estimated to remove 1.4 million elderly taxpayers from the rolls, and reduce the tax burden for another 3.7 million.[1]

The retirement income credit was enacted with the codification of the Internal Revenue Code in 1954. The purpose of the credit was to extend tax treatment parallel to the exemption of Social Security income to those whose retirement income came primarily from non-Social Security covered employment or independent savings. Persons 65 and older or under 65 and receiving a public pension were allowed to take a tax credit equal to 15 percent of their pension and, in the case of those 65 and older, interest and dividend income. The amount of retirement income qualifying for the tax credit did not include earned income over certain limits nor Social Security or other tax-exempt benefits. In 1976, the Congress limited the credit to those 65 and older with low incomes and renamed it the elderly tax credit. Targeting was achieved by placing a ceiling on the amount of the credit and by reducing the amount credited for tax-exempt retirement income and adjusted gross earnings. The credit for those under 65 was not modified in 1976, but was eliminated in the 1983 Social Security Amendments. At the same time, the tax credit for those 65 and older was increased by doubling the maximum tax credit amount.

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[1] U.S. Congress. Senate. Committee on Finance. Revenue Act of 1948; Report to accompany H.R. 4790. 80th Cong., 2d sess. Washington, U.S. Govt. Print. Off., 1948, p. 21.

The one-time home sale capital gains exclusion originated in the Revenue Act of 1964. At the time it was viewed as a way to protect homeowners from incurring tax liability on gains which were thought to result largely from inflation; some concern was voiced that a one-time exclusion should be made available to all homeowners. An additional concern, however, was that the Government should not tax away assets people had accumulated for retirement and should not discourage the elderly from selling their homes. The capital gains tax was seen as a substantial burden for the elderly in the case of home sales. The original provision was a one-time exclusion from capital gains of $20,000 in the adjusted sales price of the house for persons 65 and older. In recent years, the Congress has raised the maximum amount of excludable gain to $125,000 to reflect increases in average market prices for housing and has lowered the age after which the exclusion can be taken to 55.

These exclusions and deductions enable many of the elderly to pay no taxes at all. In 1981, 10.4 million persons 65 and older, only 40 percent of the aged population, paid income taxes.[2]

The elderly who do pay taxes, however, pay higher taxes on average than the nonelderly. Elderly taxpayers in 1981 had higher effective tax rates, 18.9 percent; and greater tax liability, $4,191, than nonelderly taxpayers, 16.2 percent and $3,647 respectively, despite the fact that the average adjusted gross income [AGI] of elderly taxpayers, $22,205, was slightly lower than the average AGI for nonelderly taxpayers, $22,460.[3]

The difference in tax liability may, in part, be due to a greater tendency among the elderly to claim the standard deduction rather than to itemize. In 1981, 30 percent of the elderly itemized their deductions, compared to 34 percent of the nonelderly. While fewer elderly itemized their deductions, those who did claimed higher average deductions than nonelderly itemizers. Overall, the elderly claimed an average of $8,774 in total deductions compared to an average of $8,064 claimed by the nonelderly. Average deductions for medical expenses and charitable contributions claimed by the elderly were more than twice those claimed by the nonelderly.

I. Issues

(A) TAX EQUITY AND EFFICIENCY

A major concern that has developed with regard to the current income tax system is that its complex array of exemptions and deductions causes distortions in economic incentives, inequities in the distribution of the tax burden and too many opportunities for tax sheltering.

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[2] Internal Revenue Service. Statistics of Income, 1981, Individual Tax Returns, table 2.5.

[3] Holik, Dan and John Kozielec. Taxpayers Age 65 and Over, 1977-1981. SOI Bulletin, 4:1-16, summer 1984.

The fairness of the tax system is usually judged in terms of vertical and horizontal equity. Vertical equity means that tax burdens are distributed in relation to the taxpayer's ability to pay—those with more income pay proportional taxes. Horizontal equity means that individuals in similar circumstances are taxed at the same rate. The current progressive income tax has a fair degree of vertical equity, but the complex system of exemptions and deductions results in substantial horizontal inequity, since individuals in similar circumstances can be taxed at widely varying rates.

Generally, the special tax provisions for the elderly are not considered to be inequitable. A 1982 Treasury Department study examined the distribution of tax benefits among higher income groups. The study ranked tax expenditures in terms of the percentage received by taxpayers with 1981 adjusted gross income [AGI] exceeding $50,000. Overall, the 4.4 percent of the taxpayers with more than $50,000 in AGI accounted for 32.9 percent of taxes after credits. The study found that the most regressive of the tax provisions specifically benefiting the elderly—the one-time exclusion of capital gains from home sales—was ranked only 16th among the 33 benefits studied in terms of regressivity, with 27.6 percent of its benefits going to those with AGI's in excess of $50,000. The double exemption for the elderly was ranked 22d—of its benefits, 15.2 percent went to the highest income brackets. The least regressive of the special elderly provisions, the elderly tax credit, was ranked 30th out of 33 benefits. Only 2.2 percent of its benefits went to those with AGI's in excess of $50,000.[4]

There is a growing sense, however, that the tax system in general benefits the rich at the expense of working people and that this sense of unfairness is contributing to a decline in taxpayer compliance. Tax legislation to raise tax revenues to reduce the budget deficit has attempted in recent years to respond to these concerns. In the Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA], and again in the Deficit Reduction Act of 1984 [DEFRA], the Congress focused on closing tax "loopholes," broadening the tax base by including more items in taxable income, limiting exemptions and deductions, and improving taxpayer complicance. These revenue-raising "reforms" have largely been promoted as means of improving the fairness of the income tax.

(B) EFFICIENCY

The efficiency of the individual income tax is judged in terms of its effects on relative prices and the allocations of resources. Any income tax distorts relative prices and is inherently inefficient. However, tax exemptions and deductions in particular are inefficient since they are specifically designed to alter relative prices, often to achieve particular social policy aims. In addition, they often have unintended effects on labor supply and consumption which do not contribute to social policy aims. Tax reform efforts to simplify the tax code, lower marginal tax rates and eliminate many current tax deductions and exemptions are often promoted as a way to reduce the work and savings disincentives which are inherent in the current tax system. Proponents of reform argue that the progressive tax structure results in high marginal tax rates which discourage people from working additional hours or raising their gross incomes. A flat tax rate would eliminate the effect of taxing additional dollars of income at increasing marginal rates. It is also argued that a reduction in marginal tax rates would improve the after-tax rate of return on investment and reduce the disincentives to save.

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[4] U.S. Congress. Joint Economic Committee. Treasury Study on the Distribution of Tax Expenditures. Press release, 97th Cong., 2d Sess., Nov. 20, 1982.

(C) SIMPLICITY

The tax law with its host of exemptions and deductions has become increasingly complex and costly to administer. The diversity of regulations and multitude of forms and procedures confuse taxpayers, and thus reduce compliance with the law. As a result, the administrative requirements and tax losses are becoming increasingly costly to both the Federal budget and the economy.

The tax law is not uniquely complex for the elderly, but the elderly especially can become confused by changes in their tax liability resulting from changes in their status. Retirement in particular causes a transformation in the sources and tax treatment of income. The tax rules that become applicable can be confusing, particularly since the tax treatment of some income may change over time or vary under alternative rules. For example, pension income is taxed under one of two alternative rules which permit the recovery of employee contributions tax free while taxing employer contributions and earnings on the trust. Often, people who have had all of their taxes withheld from their wages and have claimed only the standard deduction during their working lives are not prepared to sort out their tax liability on pension and asset income and accurately file estimated quarterly tax payments during the taxable year.

2. Legislation in 1984

Tax legislation in 1984 continued to proceed along two separate tracks. On one track, the annual effort to find additional tax revenues to help close budget deficits proceeded through the Congress yielding the Deficit Reduction Act of 1984 [DEFRA]. DEFRA was a particularly far-reaching tax bill, making major changes in the tax treatment of corporations, real-estate transactions, life-insurance companies and products, employee benefits, and investments and tax shelters, among other things. However, it made only modest changes in individual tax provisions, and it had little effect on the tax payments of the elderly as a group.

The only 1984 tax law change of unique interest to the elderly was the DEFRA provision authorizing the Secretary of the Treasury to waive penalties for failure to make estimated quarterly tax payments. A few other provisions of DEFRA affected tax payments of individuals generally, however, and will thus affect the elderly along with other taxpayers.

On the second track was an effort to simplify the income tax and redistribute the tax burden without raising any additional revenue. In recent years a number of major "flat-rate" tax and "modified flat-rate" tax proposals have been introduced in the Congress toward this end. The growing interest in a flat tax culminated with the submission of a Treasury proposal for a modified flat-rate tax to the President on November 27, 1984.

(A) DEFICIT REDUCTION ACT OF 1984 [DEFRA]

DEFRA was, as one investment firm phrased it, "* * * the first tax act in U.S. history to be driven specifically by Federal budget deficits."[5] The legislation was focused primarily on corporations, modifying the tax treatment of life insurance companies and products, partnerships, investments and tax shelters, international business transactions, real estate transactions, employee benefits, and corporations generally. Relatively few of its provisions will directly affect individual taxpayers. The major individual taxpayer changes occurred in eight areas: estimated income taxes, interest-free loans, domestic relations, charitable contributions, simplification of tax credits, earned income tax credit, income averaging, and net interest exclusion. The provision of direct significance to the elderly was the change in estimated tax penalties.

(1) Estimated income taxes.—Many people do not realize that when they retire, the shift from reliance on wage and salary income to pension annuities, dividends, and interest may require that they file a declaration of estimated tax and make quarterly tax payments. Those who fail to file the declaration and pay quarterly estimated taxes are subject to a penalty which is equivalent to the interest on the taxes owed. In 1979, about 313,000 tax returns incurred penalties as a result of failure to pay estimated taxes, primarily because of taxable pensions.

Several changes in the law over the last 4 years have helped to moderate the effect of this penalty. A provision in the Economic Recovery Tax Act of 1981 raised the threshold for liability for the penalty to $500 from its previous level of $100, effective in 1985. Thus, many older persons with only small amounts of tax liabilty will no longer be subject to a penalty if they fail to file. In addition, the Tax Equity and Fiscal Responsibility Act of 1982 instituted withholding of tax payments from pension annuities, thus reducing the need to file estimated quarterly payments, although the elderly may elect not to have their taxes withheld.

Despite these changes in the law, elderly taxpayers continued to fail to file required estimated tax payments and the Secretary of the Treasury was bound by statute to impose the penalty. To correct this situation, Senators Kassebaum and Heinz introduced legislation—S. 2257—on February 4, 1984, to authorize the Secretary of the Treasury to waive the penalty if elderly or retired taxpayers failed to file estimated tax payments "for reasonable cause." This bill was added as an amendment to DEFRA when it reached the Senate floor and was enacted in modified form as part of that legislation.

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[5] Touche Ross, The 1984 Tax Act: An Executive Summary, p. v.

The provision as enacted generally simplified and clarifies the estimated tax requirement for all taxpayers. Estimated taxes that are paid must be equal to the lesser of 80 percent of the current year tax or 100 percent of the previous year tax. Underpayments of the tax from this amount are subject to penalty, but the Secretary may waive the penalty if circumstances are unusual or where it would be inequitable to impose the penalty. The Secretary may also waive the penalty for the first 2 years after the taxpayer becomes elderly—62 and older—or disabled if failure to make the payment is due to reasonable cause. The provision is effective for taxable years after 1984.

(2) Earned income tax credit.—DEFRA increased the refundable earned income credit for low-income wage earners to 11 percent of the first $5,000 of earned income. The maximum credit will thus rise from $500 to $550 and the credit will phase out between $6,500 and $11,000.

(3) Below market/interest-free loans.—The Congress revised the tax treatment of low- or no-interest loans to prevent the use of interest free loans to transfer tax-free income to family members, employees, or others. As a result of the change enacted in DEFRA, low- and no-interest loans are now characterized as two transactions: An interest-bearing loan to the borrower at a statutory rate, and a gift of the interest from the lender to the borrower. However, the law exempts loans with an outstanding balance of less than $10,000, and does not impute income to those with a net investment income of $1,000 or less.

(4) Charitable contributions.—DEFRA made a number of small changes in the rules for deductions of charitable contributions. As a result of DEFRA changes, deductions of property donations in excess of $5,000 per donee will require an attached property appraisal, and organizations receiving such property donations will be reguired to report a sale within the next 2 years. DEFRA also raised the limits for deductions of cash and property donations to private foundations.

(5) Tax credit simplification.—In the past tax credits have been applied against the income tax in the order in which they were enacted. DEFRA replaced this with a specified order, with personal tax credits allowed against tax before other credits.

(6) Income averaging.—DEFRA requires that year-to-year income fluctuations be greater than previously required before income averaging rules apply.

(B) TAX REFORM

Several major tax reform bills were introduced in the 98th Congress to replace the current progressive structure with flat tax rates and a broad definition of taxable income. Two of the proposals became particularly prominent in the 98th Congress: the Bradley-Gephardt "Fair Tax Act" and the Kemp-Kasten "Fair and Simple Tax" [FAST]. In addition, in November 1984, the Treasury Department reported to the President its recommendations for reform of the tax system using a modified flat tax.

These three proposals have in common several objectives. All three proposals are grounded in the effort to improve the fairness or perceived fairness of the tax system. This is achieved largely through an expansion of the tax base: counting noncash compensation—employee benefits and fringes—as income and eliminating tax deductions and exclusions often only available to and certainly worth more to high-income taxpayers. In addition, all the proposals seek to simplify taxation—to reduce the need for ordinary taxpayers to maintain detailed records or pay for professional assistance, and make it easier for people to comply with the law. This is achieved largely by the use of a flat-rate tax and the elimination of many tax deductions. The proposals have also, to a greater or lesser degree, avoided redistributing the tax burden across income classes, although all three redistribute the burden substantially within classes. Finally, all three proposals have aimed at "revenue neutrality," that is, not increasing the aggregate tax burden.

Despite their broad similarities, the three proposals differ on a number of points.

(1) Tax treatment of Social Security.—Two of the flat-tax proposals—Bradley-Gephardt and Treasury—would retain the current tax treatment of Social Security and railroad retirement benefits. The Kasten-Kemp bill would increase the taxation of Social Security. Under current law, half of the Social Security benefits are taxable if the sum of the individual's modified gross income and one-half of his Social Security benefits exceeds the specified base amount. The base amount is $25,000 for individuals filing separately and $32,000 for couples. Under the Kemp-Kasten proposal, Social Security benefits in excess of $10,500 for a joint return or $7,000 for other returns would be included in taxable income. In no case, however, would Kemp-Kasten tax more than half of the total amount of the Social Security benefits received in a year.

(2) Personal exemptions.—All three proposals modify the personal exemptions. Under current law, every taxpayer is eligible for a $1,000 personal exemption—$2,000 for a joint return. The exemption for each dependent is also $1,000, and an additional exemption is available for the elderly and the blind. The current law standard deduction is $2,300 for a single and $3,400 for a joint return. The Bradley-Gephardt proposal would raise the personal exemptions and standard deductions, and leave the additional exemption for the elderly and the blind intact. The Kemp-Kasten and Treasury proposals would raise the personal exemptions and standard deductions even more, and would repeal the additional exemption for the elderly and blind. These changes would raise the level of income a family of four—filing jointly—could receive with no tax liability to $11,200 under Bradley-Gephardt, $11,800 under the Treasury proposal, and $12,540 under Kemp-Kasten. In both the Kemp-Kasten and Treasury proposals, the elderly would not be affected by the change in exemptions, although others would be benefited. In the Bradley-Gephardt proposal, the elderly, like others, would benefit from the increased exemption.

(3) Tax credits.—Both Bradley-Gephardt and Kemp-Kasten would repeal the tax credit for the elderly and disabled. The Treasury proposal would replace the elderly and blind exemptions with an improved tax credit for the elderly, blind, and disabled. The dollar amounts for the earned income tax credit would be indexed under the Treasury proposal—to maintain their relative value—and

would be reduced and indexed under Kemp-Kasten. Bradley-Gephardt would leave them unchanged.

(4) Itemized deductions.—The itemized deductions of greatest interest to the elderly—medical and charitable contributions—would be retained under most proposals, although charitable contributions would be repealed in the Treasury proposal. In addition, all three proposals would repeal the deduction for certain types of State and local taxes.

(5) Tax rates.—In all of the proposals the current system of progressive tax rates is replaced with a single tax rate or stepped flat-tax rates. Bradley-Gephardt would apply a flat 14-percent tax rate to all income, but would add a surtax of up to 16 percent on income above certain levels. Kemp-Kasten would impose a single tax of 25 percent on all income below the Social Security taxable maximum, and would tax income above the taxable maximum at 20 percent. The Treasury would used three tax rates, 15, 25, and 35 percent to retain a greater degree of progressivity in the tax system.

(6) Affect on the elderly.—In general, the elderly are disadvantaged by some provisions and advantaged by others. An understanding of the net affect of tax reform on the elderly as a group or specific types of elderly must wait for more sophisticated data. In general, many of the tax provisions in the current code which are of special benefit to the elderly would either be retained or replaced with comparable treatment. For example, in the Kemp-Kasten proposal, although the exemption for the elderly would be repealed, the standard personal exemption is raised to provide an equivalent opportunity to all taxpayers. In addition, the deductions of greatest value to the elderly, such as those for medical expenses and charitable contributions, are largely retained. On balance, the flat-tax proposals would generally lower effective tax rates for people who take standard deductions, increasing effective rates for those who have generally itemized. Since the elderly are more likely to take standard deductions, tax reform might actually reduce the net tax burden on the elderly as a group.

3. Prognosis

Tax reform will most likely be addressed as a serious issue in the 99th Congress. Concerns about the fairness of the tax system have been mounting, and there is growing awareness that the complexity of the current system among other things, is causing low levels of voluntary compliance with the tax law. Now that there is a formal proposal from the Treasury, the likelihood of a serious effort to enact a tax reform bill has increased. However, tax reform may well be too complex for it to move through the Congress in a single piece. Also, the need for revenues may eclipse efforts to enact revenue-neutral tax reform. Indeed various special provisions for the elderly may well become targets for raising revenues as part of the ongoing deficit reduction effort.

B. SAVINGS

Between 1976 and 1983, the Internal Revenue Code experienced a period of expansion of the tax incentives designed to encourage individual savings. The Deficit Reduction Act of 1984 (Public Law

98–369), with one principal exception, reversed this trend. Concerns over mounting Federal budget deficits heightened the determination of some Members of Congress to check erosion of the Federal tax revenue base. There is a growing realization in Congress that Federal resources are not unlimited, and specific tax-preferred activities will have to compete for continued favorable treatment. Among these tax-favored programs are capital accumulation plans sponsored by employers, as well as individual retirement accounts [IRA's].

The first serious discussions of generic tax reform in 1984 raised questions about the prospects for tax-favored savings in the face of a redefinition of the basic structure of the Tax Code and a broadening of the Federal revenue base. The key to legislation affecting tax incentives for individual retirement savings as well as private pensions may well rest with the fortunes of the larger tax reform debate.

1. Issues

Since 1981, public policy has placed considerable emphasis on increasing the amount of capital available for investment. By definition, increased investment must be accompanied by an increase in savings. Total national savings comes from three sources: individuals save some of their personal income, businesses retain a portion of their profits, and the Government saves when its tax revenue exceeds expenditures. As part of the trend to increase investment generally, new or expended incentives for personal savings and capital accumulation were enacted.

Simultaneous to this emphasis on capital accumulation, retirement income experts suggested that personal savings be increased for retirement-specific purposes. Many retirees are primarily dependent on Social Security for their income. Thus some analysts favor a better balance between Social Security, pensions and personal savings as sources of income for retirees. The growing financial crisis which faced Social Security in the early 1980's reinforced the sense that individuals should be encouraged to increase their preretirement savings efforts. Though this need may have been of secondary importance to more general capital accumulation goals, Congress' actions nevertheless presented new opportunities to accumulate tax-deferred savings for retirement.

The dual interest in increased capital accumulation and improved retirement income adequacy resulted in the expansion of tax incentives for personal retirement savings, such as IRA's, in the Economic Recovery Tax Act of 1981 [ERTA, Public Law 97–34]. Despite Congress' favorable disposition toward such incentives, debate continues over the importance and efficiency of expanded tax incentives for personal savings as a means to raise capital for national investment goals. Retirement income analysts have also questioned whether the incentives will create significant net new retirement savings. Each of these issues may receive further attention in 1985 in the context of efforts to limit Government spending in the wake of Federal budget deficits.

(A) TAX-FAVORED SAVINGS AND NET CAPITAL FORMATION

The effort to increase national investment springs from a perception that governmental, institutional and personal savings rates are lower than the level necessary to support a healthy economy. For the purposes of this discussion, attention can be focused on personal savings in particular. Except for a period during World War II, when personal savings approached 25 percent of income as attention was focused on the war effort, savings has with cyclical variations ranged between 5 and 8 percent of disposable income during the postwar period. Many potential causes for these variations have been suggested, including demographic shifts in the age and composition of families and work forces and efforts to maintain levels of consumption in the face of inflation. Cyclical variations aside, personal savings rates in the United States have historically been substantially lower than in other industrialized countries. In some cases it is only half to a third of the savings rates experienced by our European counterparts.[7]

Assuming present tax policy creates net new personal savings, critics suggest this may not guarantee an increase in total national savings available for investment. They argue that budget surpluses constitute savings as well; the loss of Federal tax revenues resulting from the tax incentives may offset the new personal savings being generated. Under this analysis net national savings would be increased only when net new personal savings exceeded the Federal tax revenue foregone as a result of tax-favored treatment. Otherwise the effect could be to decrease total national savings by increasing Federal budget deficits.

(B) THE PERCEIVED NEED FOR TAX INCENTIVES TO ENHANCE RETIREMENT INCOME ADEQUACY

Recent studies shed some light on the composition of the income of the retired population.[7] The proportion of aged units reporting receipt of asset income has increased gradually over the last decade: from 49 percent in 1971, 56 percent in 1976, 66 percent in 1980, to 68 percent in 1982. Some of this increase may be due to improvements on survey questionnaires which increases the accuracy of asset income reporting. However, the consistency of the upward trend suggests that some degree of real growth appears to have taken place.

Three observations about these data are appropriate. First, the prevalence of asset income receipt is nearly the same across age groups: The difference between the 55 to 61 age cohort and those age 80 years or over was only 2 percentage points. Second, the incidence of asset income receipt by sex and race for those over 65 shows substantial distributional variations. Men are more likely to receive asset income in retirement than women; whites are more likely to receive asset income than blacks. This generally reflects

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[6] U.S. Department of Commerce. International Economic Indicators, vol. VII, No. 4. Washington, December 1982.

[7] Grad, Susan. Income of the Population 55 and Over, 1982. Social Security Administration, Office of Retirement and Survivors Insurance and Office of Policy. Washington, U.S. Govt. Print. Off., March 1984. See also, Upp, Melinda. Relative Importance of Various Income Sources of the Aged, 1980. Social Security Bulletin. Washington, U.S. Govt. Print. Off., January 1983.

the increased probability that women and blacks have retirement income equal to or less than 125 percent of the poverty line. Finally, the likelihood of asset income receipt is directly proportional to total income. Only a third of aged units with income less than $5,000 receive income from assets at all, while 86 percent of those with incomes between $10,000 and $20,000 and 96 percent of those with incomes over $20,000 receive some asset income.

Historically income from savings and other assets has furnished a small but growing portion of total retirement income. In 1982, 25 percent of total money income came from asset income compared to about 16 percent 15 years ago. Assets remain a far more important source of income for the retired population as a whole than pension annuities, largely because less than one in three retirees receive pension benefits. Asset income is much more important to individuals with high levels of retirement income, however. More than one-quarter, 28 percent, of aged units with incomes greater than $20,000 relied on assets to provide more than half of their retirement income. Only 9 percent of those with income less than $5,000 relied on assets for more than half their retirement income, and of these, most depended on assets to provide 100 percent of their retirement income.

In view of these findings concerning overall levels of asset income in retirement and its uneven distribution across income groups, virtually all recent studies of national retirement policy have recommended strengthening individual savings for retirement. Because historical rates of after-tax savings have been low, emphasis has frequently been placed on tax incentives to encourage savings in the form of voluntary tax-deferred capital accumulation mechanisms.

The final report of the President's Commission on Pension Policy, issued in February 1981, recommended several steps be taken to improve the adequacy of retirement savings including the creation of a refundable tax credit for employee contributions to pension plans and individual retirement savings. Similarly, the final report of the National Commission on Social Security recommended increased contribution limits for IRA's. In September of the same year, the Committee for Economic Development—an independent, nonprofit research and educational organization—issued its report entitled "Reforming Retirement Policies." The committee recommended a strategy to increase personal retirement savings which included tax-favored contributions by employees covered by pension plans to IRA's, Keogh plans, or the pension plan itself.

These recommendations reflected ongoing interest in increased savings opportunity. Each successive Congress since the passage of the Employee Retirement Income Security Act in 1974 has seen successful attempts to expand tax-preferred savings devices and rationalize the treatment of retirement savings plans available to individuals. This was most obvious in the passage of ERTA in 1981. From the perspective of retirement-specific savings, the most important provisions were those expanding the availability of IRA's, simplified employee pensions [SEP's], Keogh accounts and employee stock ownership plans [ESOP's]. ERTA was followed by additional expansion of Keogh accounts in the Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA], which sought to equalize the treatment of contributions to Keogh accounts with the treatment of contributions to employer-sponsored defined contribution plans. But the rapid expansion of these tax incentives has taken place despite the reservations of some observers concerning their efficacy in improving retirement income adequacy.

For a number of years the "life-cycle" theory of savings has been advanced by some analysts to explain personal savings behavior. It postulates that individuals save little as young adults, increase their savings in middle age, then consume those savings in retirement. Survey data suggests that savings behavior is largely a function of available income versus current consumption needs, an equation which changes over the course of most individuals' lifetimes.[8]

The consequences of the life-cycle savings postulate raises questions for Federal savings policy. Tax incentives may have their greatest appeal to those already saving at above-average rates: taxpayers who are reaching maturity, earning above-average incomes and subject to relatively high marginal tax rates. Whether this group is presently responding to these incentives by creating new savings, or simply shifting after-tax savings into tax-deferred vehicles is a continuing subject for disagreement among policy analysts. For remaining taxpayers, who are young or earning lower incomes, the tax incentives may be of little value. Expanding savings in this group necessitates a tradeoff of increased savings for current consumption, a behavior which they are not under most circumstances inclined to pursue. As a result, some observers have concluded that tax incentives will contribute little to the adequacy of retirement income for most individuals, especially those at the lower end of the income spectrum.

2. Legislation Enacted in 1984

The Deficit Reduction Act of 1984 contains several provisions directly relevant to employer sponsored capital accumulation plans which may or may not be retirement savings specific, as well individual retirement savings programs. As with the pension provisions of DEFRA, new rules affecting capital accumulation and individual savings plans grew from a mixture of motives. Some provisions were attempts to limit perceived abuse of the Tax Code, while another was simply an effort to terminate an obsolete retirement program. Only the provisions effecting ESOP's substantially expanded current tax incentives.

Taken together with the pension and fringe benefit provisions, the new capital accumulation and savings rules appeared to issue a signal that the recent rapid expansion of tax-favored savings incentives, with few exceptions, will not continue in the face of mounting Federal budget deficits. As part of efforts to check erosion of the Federal tax revenue base, restrictions were placed on the continued growth of various fringe benefits, including so-called cafeteria plans, which frequently include a tax-favored savings component, and cash-or-deferred compensation arrangements. Congress also removed from the final version of the act an increase in the permissible maximum contribution to IRA's for nonemployed spouses on the grounds that it would increase revenue losses.

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[8] Two such surveys include the survey of changes in family finances [SCFF] commissioned by the Federal Reserve Board and the Department of Labor's personal consumption expenditures surveys [CES], which tend to confirm the rise and then fall of savings rates as individuals. See also, Wachtel, Paul. The Impact of Demographic Changes on Household Savings, 1950–2050; and President's Commission on Pension Policy. Coming of Age: Toward a National Retirement Income Policy. Washington, technical appendix, ch. 30, February 1981.

(A) EXTINCTION OF THE RETIREMENT BOND PROGRAM

The Internal Revenue Code has for some time authorized a retirement bond program that operated as an alternative to employer plans or IRA's. Individuals could purchase the bonds in much the manner they might purchase U.S. savings bonds, but with the typical tax advantages available for other tax-qualified retirement savings plans. The bond program has been little used in recent years. Originally they had fixed interest rates, which made them unpopular investment vehicles during the period of high inflation experienced in the 1970's.

Unfortunately for those who already owned retirement bonds, the IRC did not include any provisions to permit holders of the bonds to roll them over into IRA's, nor could they be cashed in until the holder reached age 59½. They were stuck with bonds that returned substantially below-market yields. In 1982, Congress authorized the Treasury to promulgate regulations establishing an indexed retirement bond system. But by that time they were so rarely purchased that the regulations were never issued. DEFRA finally extinguished the retirement bond program, and permits bondholders to cash them in and roll over the balance to an IRA or other qualified retirement plan.

(B) CASH-OR-DEFERRED-ARRANGEMENTS [CODA'S]

DEFRA clarified the rules which govern salary-reduction CODA plans. Authorized under section 401(k) of the IRC, it had been unclear precisely which antidiscrimination rule had to be met for the plan to be tax qualified. Some employers were aggregating their 401(k) plans with other qualified plans, as well as benefits provided by social security, to determine whether their total retirement benefits package was discriminatory in favor of highly compensated employees. The effect of combining all benefits before applying the discrimination test is its tendency to hide the salary reduction differential between employees at opposite ends of the wage scale. The purpose of the 401(k) provision is to encourage retirement savings by lower income employees. If they do not actively utilize their CODA plan, it becomes little more than a tax shelter device.

DEFRA settled on the more restrictive of the available test alternatives. The percent of salary deferred by highly compensated employees cannot exceed the percent deferred by a company's remaining employees by more than a certain amount specified in the IRC. In applying this antidiscrimination test, the employer can no longer combine salary deferrals with social security benefits and then test for the permissible differential between the highest paid third of a company's employees and the remaining two-thirds.

(C) CONTINUED LIBERALIZATION OF EMPLOYEE STOCK OWNERSHIP PLAN PROVISIONS

As in several recent tax bills, DEFRA included additional inducements to the formation of employee stock ownership plans [ESOP's]. To encourage banks to help finance leveraged ESOP loans, the act provides a 50-percent exclusion from taxation of interest received or accrued on ESOP loans. It also allows a special corporate deduction for cash dividends paid with respect to stock held on the dividend record of an ESOP or PAYSOP (a particular form of ESOP with a payroll-based tax credit incentive). In 1981, ERTA set the maximum tax credit for an employer's PAYSOP contributions at one-half of 1 percent for 1983-84 and three-fourths of 1 percent for 1985-87. In exchange for these liberalizations and other technical corrections, the maximum tax credit was frozen by DEFRA at one-half of 1 percent until it expires in 1987, and a 10-percent penalty excise tax has been imposed for certain premature plan distributions within 3 years of receipt.

(D) CHANGES TO INDIVIDUAL RETIREMENT ACCOUNT RULES

In continuance of the trend to rationalize the treatment of employer-sponsored and individual retirement savings plans, the distribution rules, as amended, applicable to qualified retirement plans will apply to IRA's as well. DEFRA also includes a change in the treatment of IRA's for divorced depositers which reflects the kinds of concerns addressed in the Retirement Equity Act. The contribution rules were amended to allow divorced persons to utilize the full $2,000 limit—under prior law certain divorced persons were limited to $1,125 or 100 percent of compensation—and to count all alimony as compensation for contribution purposes.

3. Continuing Policy Debates

The evolution of Congress' attitude toward expanded use of tax incentives to achieve socially desirable goals holds important implications for tax favored retirement savings. In an environment where there is increasing competition for Federal tax expenditures between programs entrenched in the Internal Revenue Code, the continued existence of tax incentives depends in part on whether they can stand scrutiny on the basis of equity, efficiency in delivering retirement benefits, and their value to the investment market economy. If 1985 sees serious efforts to reform the structure of the Internal Revenue Code, almost all of the current tax incentives in the IRC will be forced to rationalize their existence, including incentives for retirement savings.

(A) CONTINUED GROWTH OF IRA DEPOSITS

Since the expansion of the IRA program by ERTA in 1981, contributions to and assets held by IRA depositors have increased dramatically. IRA and Keogh deposits totaled $120.2 billion by the end of the first half of 1984, compared to the $25.7 billion total accumulated over the entire period from 1975 to 1981. ETRA broadened IRA eligibility so that individuals already participating in pension plans could contribute to an IRA as well. IRS data for 1982, the first year of universal IRA availability, recorded $12.1 million contributions to IRA's: nearly four times the number contributing in 1981.[9] However, the historically high interest rates and stock market gains prevalent during portions of the last 3 years may have accounted in part for this growth.

Even if IRA contribution growth is now beginning to level off, the program is already much larger than Congress anticipated. IRA deposits are tax-deferred, and thus have a present tax revenue impact even though depositors will ultimately incur some tax liability when withdrawals are made from their accounts. The final committee conference report on ERTA estimated revenue losses due to IRA deposits at $0.98 billion for 1982 and $1.35 billion in 1983. Based on actual contribution for those years, EBRI estimated the Federal revenue loss to be closer to $15.2 and $14.6 billion respectively. These figures suggest that the sudden expansion of the IRA program may become an important policy issue in the 99th Congress. IRA's constitute a major short-term revenue loss to the Federal Government, which may now equal as much as one-third the revenue loss attributable to tax expenditures on public and private employer pension plans.

The rapid growth of IRA's poses a dilemma for employers as well as Federal retirement income policy. As IRA's come to play an increasingly more important role in the retirement planning of employees, they may diminish the importance of the pension bond which links the interests of employers and employees. Employers may indeed face new problems in attempting to control the composition of their work forces. They design pension plans in a manner that permits them to influence, to some degree, job mobility and retirement behavior. The increased availability of IRA's and the growing reliance of employees on them reduces the incentive of employees to participate in employer-sponsored retirement plans generally, and defined contribution plans in particular.

(1) The Effectiveness of IRA Tax Incentives

The size of current IRA deposits, coupled with the distribution of taxpayer IRA participation by income, age, job tenure, and pension coverage characteristics raises serious public policy questions. There are two principal dynamics to the effect of IRA contributions on aggregate savings, each of which will be addressed in turn. First, is the IRA tax incentive effectively utilized by those individuals Congress desired to target for increased savings? Second, does the IRA tax incentive successfully create new savings?

To analyze these issues, a picture must first be drawn of the characteristics indicative of IRA utilization. Participation rates among low-wage taxpayers, from zero to $20,000 annual income, is two-fifths that of middle-income taxpayers, $20,000 to $50,000 annual income, and one-fifth that of high-income taxpayers, $50,000 or more annual income. As the life-cycle savings hypothesis suggests, employees nearing normal retirement age are three times more likely to contribute to an IRA than workers in their twenties.

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[9] Employee Benefit Research Institute. Individual Retirement Accounts: Characteristics and Policy Implications, EBRI Issue Brief No. 32, Washington, July 1984.

Employees with job tensures greater than 5 years display a higher propensity toward IRA participation at all income levels. For those not covered by employer pensions, utilization generally increases with age, but is lower across all income groups than for those who are covered by employer pensions. In fact, 46 percent of IRA accounts are held by individuals with vested pension rights.[10]

One of the stated objectives of ERISA's creation of IRA's, as well as ERTA's expanded IRA eligibility, is to provide a tax incentive for increased savings among those in greatest need. This need appears to be most pressing among those with low pension coverage and benefit receipt resulting from employment instability or low average career compensation. If we examine the characteristics of those most likely to establish IRA's, however, the tentative conclusion is that IRA utilization increases with job and income stability. The tax incentive appears to be most attractive to taxpayers with relatively less need of a savings incentive, which makes sense. If those identified by public policy as in need of increased savings are not willing to trade off after-tax, but high liquidity savings for decreased present consumption, one could speculate that the tax advantage of relatively low liquidity IRA savings would have little or no marginal utility to them.

Available data does not allow analysts to consider the economic impact of the IRA program with any precision. Therefore only tentative conclusions can be drawn from this brief discussion. Though a low proportion of low-income taxpayers utilize IRA's relative to higher income counterparts, those low-income individuals who do contribute to an IRA are more likely than their high-income counterparts to make the contributions from salary rather than preexisting savings. Similarly, high-income taxpayers are apparently more often motivated to contribute to IRA's by a desire to reduce their tax liability than to save for retirement.[11] The consequence for current Federal policy is that the IRA tax incentive does create some new retirement specific savings, but at the not inconsiderable expense of high utilization of IRA's for tax shelter purposes. Whether the tax avoidance cost justifies the gain is an issue Congress may or may not be willing to reconsider.

(2) The IRA Equity Debate

The gradual expansion of the IRA program over the past decade, and the repeated proposals from the administration and from within Congress to expand it still further, suggests that Federal policy may be shifting its emphasis from employer sponsored retirement savings to individual effort. This trend, together with the growing sense that private pensions and IRA's may soon be forced by deficit reduction concerns to compete for continued tax-favored treatment, has prompted some analysts to compare the employer-sponsored plans to IRA's on the basis of equity and delivery of adequate retirement income.

"Equity" in this context can be defined to have three different meanings. First, it can be defined to mean the distribution of total pension plan and IRA participants by income level. Second, "equity" is defined by many critics of IRA's to be the percentage of taxpayers in each income level who are pension plan or IRA participants. This view breaks the work force into separate income groups and calculates IRA utilization rates within each income group. Economists more sympathetic to IRA's have a third measure of "equity." They look at the distribution of total tax expenditures to determine which income groups receive various shares of aggregate tax benefits. In this calculus, low participation rates among low-income taxpayers are offset by the fact that there are far more low-income than high-income taxpayers. Arguments over which of these three definitions of "equity" is most appropriate is the crux of the debate.

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[10] Ibid.

[11] Ibid.

It may be inappropriate to limit the policy debate to one definition, in any case, since the dynamics of each program differ. The probability that a taxpayer is a pension plan or IRA participant increases as income rises—but for apparently different reasons. More than 40 percent of the total civilian work force is uncovered by a pension through the voluntary decision of employers, not employees. Hence, the inequitable distribution of pension coverage results from decisions outside the direct control of individual taxpayers. In contrast IRA participation rates might be influenced by several factors: what stage of his or her career the taxpayer is in currently, or whether the taxpayer is a member of a one- or two-earner family. Whatever the combination of circumstances, the ultimate decision to participate in the IRA program is an individual choice. This disjunction of decisionmaking responsibility suggests that private pensions and IRA's ought to be evaluated separately on the basis of equity and efficiency, not comparatively.

The comparison between IRA's and 401(k) cash-or-deferred arrangements is marginally less difficult to draw. While employees determine the amount which will be placed into their CODA account, the availability of a salary-reduction savings plan is still at the discretion of the employer. So far relatively few employees work for firms that offer a 401(k) plan, though the number appears to be increasing steadily. Nor can the utilization rates of IRA's and CODA's be directly compared. The utilization of IRA's by high-income taxpayers is restricted only by a $2,000 annual contribution limit. Rather than impose a similar dollar cap on 401(k) plans, Congress required that they meet a nondiscrimination test which prohibits high-income employees from utilizing their accounts at rates substantially greater than low income employees. As a result, low-income employees participating in 401(k) plans do so at a higher rate than low-income taxpayers utilize IRA contributions generally,[12] but under a 401(k) plan a high-income taxpayer can probably shelter a greater percentage of his or her total annual income.

The consequence to Federal tax revenues of salary-reduction retirement savings is indeterminable at present because CODA plans are not yet very widespread, but the potential would appear to be significant. Additional study is required to determine whether 401(k) plans distribute a greater or lesser percentage of their total tax benefits to high-income employees than IRA's. If deficit reduction concerns precipitate a compromise trading off expanded growth in one type of retirement tax incentive for another, it might well take the form of further increases in the IRA program in exchange for restrictions on the growth of 401(k) plans.

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[12] Ibid.

(3) Further Liberalization of the IRA Program

Despite what may be an inequitable distribution of tax benefits resulting from IRA utilization, congressional interest in further liberalizations of the contribution limits and distribution rules applicable to individual retirement accounts continues to grow. The 98th Congress saw a variety of initiatives which collectively would have: Indexed the contribution limits for inflation; permitted additional nondeductible contributions which could accumulate tax-deferred interest; allowed early withdrawals of up to $10,000 to pay for college tuition or to purchase a house without penalty; and increased the aggregate limit for IRA contributions by a taxpayer and nonemployed spouse to $4,000.

Those who oppose liberalization of the contribution rules contend that any increase will primarily be to the advantage of middle- and upper-income taxpayers, since the small percentage of low-income taxpayers who do utilize IRA's often do not contribute the full $2,000 permitted them each year. These proposals would also decrease Federal revenues; the indexation of contribution limits represents the greatest potential for loss. For this reason, such proposals are not expected to receive favorable consideration from Congress in the prevailing fiscally restrictive environment.

A possible exception to this observation arises from recent concern over a perceived inequity in the treatment of IRA contributions for nonemployed spouses. Under current law, a two-earner household can make total IRA contributions of $4,000 per year—$2,000 for each employed spouse. But a one-earner family can only make an aggregate contribution of $2,250, though the contribution can be divided in any proportion between IRA's for each of the spouses so long as the contributions to any one of the accounts does not exceed $2,000 per year. Thus, an apparent inequity exists, not between employed and nonemployed spouses, but between one- and two-earner families. Several bills were introduced during the 98th Congress to address this disparity, and the fiscal year 1985 administration budget recommended an increase in the "spousal IRA" contribution limit to $4,000.

The reason for this distinction between one- and two-earner families is not irrational, but founded in a basic doctrine of the Tax Code prohibiting the assignment of income. If taxpayers were permitted to direct their employers to pay their wages to spouses or children, they could effectively shelter a portion of their income from taxes by having their wages paid to family members who would otherwise be in a lower tax bracket. Thus the Tax Code prohibits individuals from assigning their incomes to other persons to gain more favorable tax treatment. A tax-deductible contribution to a "spousal IRA" has the same effect as an assignment of income: the taxpayer receives a tax advantage for assigning up to $2,000 in income to his or her nonemployed spouse.

None of the spousal IRA initiatives ultimately succeeded because Congress was reluctant to authorize programs which would result in additional revenue losses. The 98th Congress, which evinced interest in women's retirement equity issues in the context of private and Federal pension plans, apparently could not justify the enactment of these proposals. It is therefore improbable that in 1985 Congress will put aside its fiscal reservations to consider the debate on the basis of equity versus a general principle of taxation.

(B) CONTINUED PROMOTION OF ESOP'S AS RETIREMENT SAVINGS PLANS

Employee stock ownership plans [ESOP's] by their nature can be used for many purposes in addition to giving employees an ownership interest in their employer's company. They can be used as a means of selling the firm, converting a public concern into a privately held company, or even as a defensive weapon in a corporate takeover battle. The fact that an ESOP can be used for so many purposes increases the risk of a conflict in interest between employer and employee, however. It is therefore important that any such actions be undertaken with the foreknowledge of plan participants.

Although ESOP's can become a valuable source of retirement income to supplement Social Security, pension benefits and personal savings, they are not designed nor intended to be an employee's sole or primary retirement savings vehicle, or a replacement for traditional pension arrangements. Such plans can offer employees potential investment returns exceeding those of standard pension plans if the company is growing at a substantial rate or is consistently profitable, but at a considerably increased risk. Employees not only bear the risk of the plan's investment performance, but also bear the additional risk of relying on a nondiversified investment portfolio. Because the value of a company's shares can fluctuate over a wide range in response to the employer's fortunes, an ESOP can not be considered a secure primary retirement vehicle for participants. Thus there has been considerable concern over recent action by some corporations which have terminated their defined benefit pension plans and replaced them with ESOP's.

The most sensitive issue surrounding employee stock ownership plans is their expanding use in closely held corporations, where the value of the stock to employees is uncertain. For employees to have meaningful ownership interest in their employer through participation in an ESOP the stock must be fairly valued and the employees must have some control over the way in which the stock is to be voted. But in a privately held corporation one or both of these elements may be missing or constrained. It is difficult to value stock contributed to the ESOP of a privately owned corporation because there is no ready market for its resale. This creates an enormous potential for abuse. By overvaluing stock contributions an employer-owner can inflate the tax benefit received while employees may be hurt because the real value of the stock is less than its nominal worth.

Although Congress has clearly expressed its intent to encourage employee stock ownership, the effectiveness of the ownership and productivity incentives which form the basis of congressional policy have been debated. In the case of ESOP's in closely held corporations with limited voting rights passthrough, the absence of voting rights and a ready market for resale cast doubt on the existence of any realistic incentive at all. Even in publicly traded corporations with full passthrough voting, some employee organizations have argued that stock in the ESOP does not accumulate fast enough compared to the total amount of stock outstanding to give employees any significant voice in corporate decisionmaking. As a result, several employee organizations have opposed the implementation of ESOP's unless coupled to representation on the employer's board of directors.

The ESOP concept appears to be viewed positively by Congress in spite of these unresolved issues. It is important to note, however, that since an ESOP's value is inextricably tied to the financial health of the employer, their implementation should be traded off against current wages rather than retirement benefits when being used to save financially distressed employers. If an ESOP is used to replace pension benefits, the demise of the employer could wipe out a substantial portion of an employee's retirement income as well. But by exchanging the ESOP for current wages an employee's retirement benefit remains insulated to some degree from the consequences of the employer's potential demise, while a much stronger link is forged between productivity incentives and the employee's present compensation.

The interests of older workers near retirement differ greatly from those of younger workers, such that an ESOP cannot be utilized as a replacement for traditional pension arrangements without having a differential effect on the interests of certain groups of employees. These factors should be considered by legislators as they contemplate further incentives to ESOP formation during the 99th Congress.

4. PROSPECTS FOR 1985

Predictions of future personal savings rates are especially tenuous because they depend on a complex set of interrelated economic factors. Congress has in recent years attempted to encourage personal savings with new tax-favored devices such as IRA's and CODA's, but each has its limitations. While employers have often found CODA's under section 401(k) to be effective in generating new savings across all income groups, they are only available to employees if their employer decides to offer a salary reduction option. As yet, only a small number of employers have chosen to do so. Some survey evidence suggests that roughly one-third of IRA deposits represent savings which otherwise would have been consumed by taxpayers. But this increased margin of savings must be weighed against the significant cost to the Federal Government of providing this tax-deferred savings mechanism. Looming budget deficits may place pressure on Congress to find new ways to encourage personal savings—or discourage personal consumption—which do not represent such a drain on Federal revenues.

The data on savings behavior available to us is not satisfactory, and many questions remain unanswered. But, we do know that, because of new tax incentives and demographic shifts in the composition of the population, savings could well play a larger role in supplying income to the elderly in the future. IRA's and 401(k) accounts will increase the number of elderly receiving retirement income from assets, but may not contribute significantly to the elimination of poverty among the elderly. From this perspective the challenges facing past Congresses remain to be addressed by the 99th Congress.

Chapter 4

EMPLOYMENT

OVERVIEW

For decades, employment and retirement policies in the United States have been directed toward encouraging early retirement. For example, Social Security was developed during the Great Depression, in part, to ease a sufficient number of older workers out of the labor force to make room for younger workers. Similarly, 9 out of 10 private pension plans offer financial incentives for early retirement; that is, prior to normal retirement age. When these programs are combined with employer administered mandatory retirement policies, a highly competitive work force and rapidly changing technologies, it is not surprising that few older persons remain employed after their 65th birthday.

The statistics on older worker employment are startling. Since 1900, the employment rate among men 65 and older has declined by nearly 50 percent. Today, only 18.8 percent of this older male age group are employed, as are only 8.2 percent of older women. The early retirement trend has also extended down to the middle-aged as well. Since 1960, employment rates among men aged 55 to 64 have dropped by one-sixth, from 87 percent to 70 percent. Three-quarters of all new Social Security beneficiaries each year retire well before their 65th birthday, and most begin collecting benefits at the earliest possible age, age 62. The average retirement age in some industries; for example, steel and auto manufacturing is even lower because of private pension inducements.

This early retirement phenomenon raises serious policy concerns. First, the future economic security of older Americans is jeopardized by early labor force withdrawal. Those who do not work are three times more likely to fall below the poverty level. Second, earlier retirement contributes to the financial strain on Social Security and private pension plans. And, serious shortages of skilled labor may develop in certain industries unless the early retirement trend is reversed. In contrast to these pressures to keep older persons in the labor force, however, it appears that labor demand is not sufficient to satisfy older persons' current employment needs. Therefore, the conflict between early retirement and the need to reverse the decline in labor force participation rates has become a major public policy dilemma.

In addition to the economic arguments for increasing the labor force participation rates among older workers, there are also compelling issues of civil rights involved. Age, like race and sex, is a protected category by Federal statute. Eliminating age bias in the workplace is consistent with a tradition in America of struggle against arbitrary policies which discriminate against individuals because of their basic beliefs or their personal characteristics. The nearly unanimous opposition to mandatory retirement policies by the American public is one indicator of the strong sentiment against arbitrary age bias in employment. Yet, despite these civil rights arguments, the protections against age discrimination remain incomplete and somewhat ineffectual.

These twin problems—the early retirement trend and infringements on the civil rights of older workers—comprise the underpinnings of the public policy debate on employment for the aging. Steps have been taken in recent years to increase incentives for delayed retirement and to remove barriers to continued employment. Nonetheless, the trend toward earlier and earlier retirement continues and complaints of age discrimination in the work force continue to grow.

Solving the employment problems of older persons will require a fundamental shift in public and private policies. Despite a broad consensus that individuals should not be discriminated against based on their age, discrimination is still widely practiced and stereotypes of useless, burned-out older workers persist. Despite an awareness by public and private policymakers that early retirement is costly for retirement income programs, as well as for the larger economy, lucrative early retirement incentives persist. Despite the recognition that workers periodically need retraining and that some job flexibility would improve their long-range productivity, there are only miniscule resources channeled toward retraining and only a handful of employers who offer alternative work options to older workers—or any workers, for that matter.

In sum, the two most important employment issues of concern to Federal policymakers are: one, age discrimination in employment, and two, the costs of early versus delayed retirements. Both of these issues and their Federal policy implications are discussed in this chapter.

A. DISCRIMINATION IN EMPLOYMENT

Numerous obstacles to older worker employment exist in the labor force. These include: (1) negative stereotypes about aging and productivity, (2) job demands and schedule constraints which are inconsistent with the skills and needs of older workers, and (3) policies which make it undesirable to remain in the labor force, such as early retirement incentives and discontinued pension credits. Several of these have their roots in age discrimination and are thereby affected by Federal statute.

Age discrimination in employment plays a pernicious role in blocking employment opportunities for older workers. It is not a new problem. The emergence of discriminatory employment practices for older workers can be traced to the late 1800's in the United States. There is some evidence that even in the late 1800's, negative attitudes about the capacities and productivity of the aged were already common throughout the Nation. The development of retirement as a social pattern in industry may have served to enhance and legitimize employment discrimination practices despite early evidence that older workers were capable, conscientious and productive employees.[1]

Public attitudes.—Today, age discrimination in employment is widespread. There is no agreement on the exact nature of the problem, nor is there a consensus on how to solve it. But few would disagree that the problem is real and that it affects the lives of millions of Americans.

Despite Federal legislation to ban most forms of age discrimination from the workplace, most Americans believe age discrimination remains a serious problem. Two nationwide surveys by Louis Harris & Associates—one in 1975, the other in 1981—found nearly identical results; 8 out of 10 Americans believe that "most employers discriminate against older people and make it difficult for them to find work." [2]

Business attitudes.—The perception of widespread age discrimination held by the public is shared by a majority of business leaders. Most employers believe age discrimination exists, according to a 1981 nationwide survey of 552 employers conducted by William M. Mercer, Inc.[3] The following key points summarize the survey's findings:

- — 61 percent of employers believe older workers today are discriminated against in the employment marketplace;
- — 22 percent claim it is unlikely that, without the present legal constraints, the company would hire someone over age 50 for a position other than senior management;
- — 20 percent admit that older workers (other than senior executives) have less of an opportunity for promotions or training; and
- — 12 percent admit that older workers' pay raises are not as large as those of younger workers in the same category.

Mandatory retirement.—The most clearcut form of age discrimination is mandatory retirement rules. According to a recent Department of Labor study, 51 percent of the Nation's work force faced an arbitrary mandatory retirement age in 1980, ususally age 70, while 45 percent faced no mandatory retirement age.[4] Mandatory retirement rules are subsiding, but they persist for a variety of reasons.

The most common argument used by employers to justify a mandatory retirement age has not changed substantially over the years, despite evidence refuting most of the stereotypes of aging. Many employers preceive older workers as a group to be ill-suited for certain jobs because of declining mental and physical capacity, an inability to learn, a lack of creativity, and inflexibility. Vast amounts of research on the abilities of older workers, however, consistently refute these employer-held stereotypes.

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[1] Graebner, W.A., A History of Retirement, Yale University Press, New Haven, CT, 1980.

[2] Harris, L., & Associates. The Myth and Reality of Aging in America. Washington, DC, National Council on the Aging, 1975. Also Harris, L., & Associates, Aging in the Eighties: America in Transition. Washington, DC, National Council on the Aging, 1981.

[3] Mercer, William M. "Employer Attitudes: Implications of an Aging Work Force." William M. Mercer, Inc., New York, NY, 1981.

[4] U.S. Department of Labor. Study on the Effects of Raising the Age Limit in the Age Discrimination in Employment Act, 1982.

The forms of age discrimination range from the more obvious mandatory retirement ages, to more subtle job harassment and early retirement incentives. Each of these represents not only a threat to the well-being of older individuals, but also undermines the economic stability of the Nation's retirement income systems and, to a lesser extent, the larger economy as well. Age discrimination reduces the work efforts of older people, encourages premature labor force withdrawal and increases the load on an already burdened Social Security system and on private pensions. Without adequate solutions to the problems of age discrimination and without incentives to encourage more older workers to remain employed longer, the Nation could be facing a serious economic as well as social crisis in the future.

The Age Discrimination in Employment Act.—In order to promote equal employment opportunities for older persons, Congress enacted the Age Discrimination in Employment Act [ADEA) in 1967, which became effective on June 12, 1968 [Public Law 90-202].

The ADEA legislation was the culmination of years of debate concerning the problems of providing equal opportunity for older workers in employment. At issue was the need to balance the competing interests of the right of the older worker to be free from age discrimination in all aspects of employment, and the employer's perogative to control the managerial decisions which make a business profitable. The provisions of the ADEA attempt to balance these competing interests by prohibiting age discrimination based upon an employer's arbitrary policies which would prevent employment of individuals above a certain age. Aribtrary age limits may not be used as conclusive determinations of nonemployability, so that employment decisions regarding older persons should be based on an individual assessment of each applicant's or employee's potential or ability.

The Age Discrimination in Employment Act was enacted in 1967 to "promote employment of older persons based on their ability rather than age; to prohibit arbitrary age discrimination in employment; and to help employers and workers find ways of meeting problems arising from the impact of age on employment." The act prohibits employment discrimination against persons aged 40 to 70. These age limits were chosen to focus coverage on workers especially likely to experience job discrimination because of their age. The upper age limit was set at 65 originally because it was the common retirement age in U.S. industry and the normal eligibility age for full Social Security benefits. The act specifies that actions otherwise deemed unlawful may be permitted if they are based upon the following considerations:

- —Where age is a bona fide occupational qualification reasonably necessary to normal operations of a particular business.
- —Where differentiation is based on reasonable factors other than age (for example, the use of physical examinations relating to minimum standards reasonably necessary for specific work to be performed on a job).
- —To observe the terms of a bona fide seniority system or a bona fide employee benefit plan such as a retirement, pension, or insurance plan, with the qualification that no seniority system or

benefit plan may require or permit the involuntary retirement of any individual who is covered by the ADEA; and

—Where an employee is discharged or disciplined for good cause.

In addition, an executive or high-ranking, policymaking employee in the private sector entitled to annual private retirement benefits of at least $44,000 could be compulsorily retired at age 65, simply because of age. This is known as the executive exemption and it was designed to allow turnover at the top levels of the organization. While it has strong support among business leaders, recent evidence shows that it is used only infrequently by a small number of employers.

Since 1967, the ADEA has been amended four times. The first set of amendments occurred in 1974, when the provisions of the act were extended to include Federal, State, and local government employers. Also, the number of workers covered was increased by exempting only those employers who have fewer than 20 employees. Previous law exempted employers with 25 or fewer employees.

In 1978, the act was amended again, this time to extend protection to age 70 for private sector, State, and local government employers, and removing the upper age limit for employees of the Federal Government. Regulations implementing the 1978 amendments, however, specified that employers are not required to credit years of service worked beyond age 65 to final pension benefit levels. This was, and continues to be, a disincentive to continued work beyond age 65.

Although the mandatory retirement age was eventually lifted for most Federal employees, the original statute and subsequent amendments did not address existing mandatory retirement ages for Federal prison guards, air traffic controllers, Foreign Service officers, Federal law enforcement and firefighting personnel, the FBI, the military, and several other Federal occupations. Also, until July 1, 1982, tenured faculty at institutions of higher education could be compulsorily retired at age 65. These issues continue to be controversial and any attempt to further amend the ADEA will surely involve debates over compulsory retirement for tenured faculty and whether the exempted Federal occupations should be covered by the act.

The act was amended a third time in 1982 by a provision included in the Tax Equity and Fiscal Responsibility Act [TEFRA]. This provision, referred to as the "working aged" clause, requires employers to retain their over 65 workers on the company health plan rather than automatically shifting them to Medicare. Under previous law, Medicare was the primary payer and private plans were secondary. Now, the situation is reversed, with Medicare acting as the payer of last resort. This provision was designed to be a cost savor for the Medicare program, but it is viewed as a new obstacle to employment for older workers because it increases the costs of employment and, for many small companies, there are serious problems in finding insurance coverage at all for these older workers.

1. LEGISLATIVE ISSUES IN AGE DISCRIMINATION

(A) SHOULD THE UPPER AGE LIMIT OF 70 IN THE ADEA BE REMOVED?

Several Senate bills in the 98th Congress would have removed the upper age limit in the ADEA—that is, S. 686, Quayle; S. 382, Heinz; S. 1751, Cranston; H.R. 1926, Solomon; and H.R. 2161, Pepper. The effect of removing the upper age limit would be to protect workers aged 40 and above against discrimination in all types of employment actions, including mandatory retirement, hiring, promotions, and terms and conditions of employment.

Organizations for the aged and others in favor of eliminating mandatory retirement argue that judging a person's qualifications for a job solely on the basis of age, without regard to fitness for a job, is inequitable and that chronological age alone is a poor predictor of ability to perform a job. Other arguments for eliminating mandatory retirement include: (1) Older workers discriminated against may lose income; (2) loss of status associated with the loss of a job may result in the deterioration of mental and physical health for the older person; (3) the loss of skills and experience from the work force due to mandatory retirement results in a loss to our Nation's productivity and gross national product [GNP]; and (4) allowing workers to stay on their jobs longer helps the financial status of the Social Security and other retirement systems because payment of full retirement benefits is deferred until a later age and continued contributions will flow into these programs.

Employers and others in favor of retaining mandatory retirement note that older persons, as a group, may be less well-suited for some jobs than younger workers because declining physical and mental capacity are found in greater proportion among older persons, and they do not learn new skills as easily as younger persons. Other arguments against eliminating mandatory retirement include: (1) mandatory retirement preserves dignity for the older worker who is no longer capable of performing his or her job adequately, and who would otherwise be singled out for discharge in a personally damaging proceeding; (2) mandatory retirement provides a predictable situation allowing both management and employees to plan for the future; (3) older workers can often retire with Social Security or other retirement income, making jobs (and promotions) available to younger workers who do not have other income potential; and (4) by opening up jobs, mandatory retirement also provides more opportunities to women and minorities who are underrepresented in certain occupations.

The Reagan administration's support for legislation to abolish mandatory retirement has been inconsistent. In April 1982, the President endorsed the elimination of mandatory retirement saying:

> I will back legislation which eliminates mandatory retirement requirements in government and private industry based solely on age.

Soon after that statement was made however, administration officials said before congressional committees that the President supported removal of the upper age limit only for forced retirement;

other aspects of employment, such as hiring and promotions, could be subject to age 70 limits, according to the administration's view. Since then, the administration has given lukewarm support to even such a narrowly focused bill.

The key political issues in the debate over mandatory retirement have little to do with the merits of the issue; there is remarkably little opposition to the full elimination of mandatory retirement. Instead, the debate hinges on three related concerns: (1) whether amendments to the ADEA should also modify the enforcement procedures specified in the original act; (2) whether an exemption (allowing mandatory retirement at age 70) should be included for termed faculty of institutions of higher education; and (3) whether an exemption allowing early forced retirement should be added for State and local law enforcement and firefighting personnel. Each of these is discussed below.

(B) SHOULD ADEA ENFORCEMENT PROCEDURES BE CHANGED?

S. 686, introduced by Senator Quayle during the 98th Congress, would have eliminated jury trials and liquidated damage awards under ADEA. This bill had support from business associations such as the Chamber of Commerce, but was vigorously opposed by aging organizations and the plaintiffs bar. Employers argue that title VII of the Civil Rights Act—which prohibits employment discrimination on the basis of race, color, sex, religion, or national origin—does not allow jury trials nor liquidated damage awards. Therefore, age discrimination cases should not be treated differently. ADEA enforcement procedures are instead modeled after those in the Fair Labor Standards Act. Some believe that juries tend to sympathize with the plight of aging plaintiffs and make unreasonably large awards.

Those in favor of retaining the procedures in current law note that liquidated damages are only payable if there is a willful violation of the act, making the provision a deterrent to such violations. Advocates for liquidated damages also say that such awards are important because judges are reluctant to order reinstatement or monetary awards beyond the date of the decision, although the plaintiff may continue to experience problems securing appropriate employment.

On the jury trial issue, there is no clear-cut evidence that juries are more sympathetic to aggrieved older workers than are judges. A recent study by Barbara Fosberg, in which 239 ADEA cases were analyzed, indicates that jury verdicts show no bias toward plaintiffs.[5]

(C) SHOULD MANDATORY RETIREMENT BE ALLOWED FOR TENURED FACULTY?

The Quayle bill [S. 686] would have reversed the 1978 ADEA amendments and allowed permanent mandatory retirement of tenured faculty at age 65. The Heinz [S. 832] and Pepper [H.R. 2161] bills would have allowed tenured faculty to be mandatorily retired at age 70 until 1998, assuming the current age 70 cap is lifted for other workers. The DOL recommends a temporary exemption for faculty at age 70, if the age cap is eliminated for others, to allow colleges and universities time to evaluate retirement trends.

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[5] Frosberg, Barbra B., A Comparison of Jury Trials and Bench Trials in Age Discrimination Cases. BIFOCAL, vol. 5 No. 3, fall 1984. Washington, DC., ABA Commission on Legal Problems of the Elderly.

As mentioned previously, an exemption in the 1978 amendments allowed mandatory retirement of tenured faculty at institutions of higher education at age 65 until July 1, 1982, when the age was raised to 70. Several points have been made in support of mandatory retirement of tenured faculty:

—According to DOL, the salaries of faculty nearing retirement are about twice those of newly hired faculty. Prohibiting mandatory retirement might exacerbate the financial problems colleges and universities are facing because of the reductions in public funds. Reduced enrollments, because of fewer numbers in the traditional college age group, mean fewer opportunities to hire new faculty.

—Prohibiting mandatory retirement may make it more difficult for higher education institutions to employ more women and minorities as faculty members.

—Governing boards and State institutions may reevaluate the tenure system if there is no mandatory retirement age. Tenure protects academic freedom by prohibiting dismissals except under specified conditions. Some would argue that without a mandatory retirement age, tenure would guarantee indefinite employment, a situation which would be unacceptable to university administrators and, thus, would eventually jeopardize the tenure system.

According to testimony before the Labor and Human Resources Committee, faculty and higher education administrators are generally in agreement in seeking a permanent exemption from any uncapping of the mandatory retirement age for tenured faculty. However, the American Federation of Teachers, and reportedly the National Education Association, oppose such exemptions for faculty.

The DOL study indicates that results of raising the retirement age to 70 for faculty include modest cost increases and decreased new faculty appointments, but the duration of the impact on higher education faculty, at least from raising mandatory retirement from age 65 to 70, will be short lived. It adds, however, that, "removal of any mandatory retirement age may pose more difficult adjustment problems." Nonetheless, those who oppose the exemption believe there are not sufficient reasons to single out faculty for special, discriminatory treatment.

(D) SHOULD THERE BE AN EXEMPTION FOR STATE AND LOCAL PUBLIC SAFETY OFFICERS?

A Senate bill [S. 2540] introduced in the 98th Congress by Senator Bradley would have exempted State and local government firefighters and law enforcement officers from protections of the act related to hiring and discharging. A similar bill [H.R. 5310] was introduced by Representative Hughes in the House of Representatives. If enacted these amendments would allow age to be a determining factor in hiring or discharging public safety officers, but such employees would still be protected from age discrimination in promotions, compensation and other terms, conditions, and privileges of employment. S. 2425, by Senator Ford, would exempt State law enforcement officers from all ADEA provisions.

The issue of whether public safety officers should be treated like other employees under ADEA arose after the Supreme Court on March 2, 1983, in *EEOC* v. *Wyoming* determined that the State's game wardens were covered by the ADEA. Wyoming's policy of mandatory retirement at age 55 for State game wardens was ruled invalid unless the State could show that age is a bona fide occupational qualification [BFOQ] for game wardens. Wyoming had not attempted to establish a BFOQ in this case, but had instead argued that application of the ADEA to the State was precluded by constraints imposed by the 10th amendment on Congress commerce powers—an argument not sustained by the court.[6]

Many States and localities have mandatory retirement age policies below age 70 for public safety officers and are concerned about the impact this decision will have. As a result, the legislation cited above has been introduced to exempt public safety officers from some or all ADEA provisions. Supporters of such legislation note that Federal law generally requires mandatory retirement at age 55 for Federal law enforcement officers and firefighters and say there is nothing to justify treating State and local personnel differently. They also argue that the mental and physical demands, and safety considerations for the public, the individual and coworkers who depend on each other in emergency situations warrant mandatory retirement ages below 70 for these State and local workers. Sponsors of the legislation believe that it would be difficult to establish that a lower mandatory retirement age for public safety officers is a BFOQ under the ADEA—as allowed in the Wyoming case—because of conflicting court decisions; and, even if possible, would require costly and time consuming litigation.

The proposed amendment to the ADEA is supported by the National Governor's Association, the National Association of Counties, the National Sheriffs' Association, the International Association of Chiefs of Police and the International Association of Firefighters. It is opposed by the American Association of Retired Persons, the National Council on Aging, and the Equal Employment Opportunity Commission.

Those opposed to exempting safety officers from the ADEA note that age affects individuals quite differently, and they say there are tests that can be used to measure the effects of age on individuals, including those that measure general physical fitness, cardiovascular condition, and reaction time.

(E) SHOULD PENSIONS BE ACCRUED PAST AGE 65?

Under the present interpretation of the 1978 amendments to the Age Discrimination in Employment Act [ADEA], pension plans regulated under the Employee Retirement Income Security Act [ERISA] are not required to continue accrual of pension credits for employees who work beyond normal retirement age. Presently, only 50 percent of the plans covered by ERISA do accrue benefits after age 65. This acts as a disincentive to employment for older workers. Under the currently allowed mandatory retirement age of 70 continued accrual of pension credits would result in an estimated 50,000 more workers age 60 to 70 in the labor force by the year 2000. If the age 70 limit was removed as well, a total of 68,000 more men age 60 to 70 probably would be in the work force by that year.[7] These statistics suggest that the discontinuation of pension benefit accruals are a modest disincentive for continued employment beyond age 65 for at least a portion of the work force.

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[6] Congressional Research Service Report, Summary and Analysis of *EEOC* v. *Wyoming*, 103 S. Ct. 1054 (1983), 460 U.S. (1983), by Karen Lewis, Mar. 15, 1984.

Following the 1978 ADEA amendments, the Department of Labor [DOL] published an interpretive bulletin on the act in May 1979. The DOL interpretation allowed employers to cease pension contributions and pension credits for active employees who work beyond the normal retirement age specified in their pension and retirement plans. Specifically, these rules interpret the ADEA to permit pension plans to: (1) cease employer contributions at "normal retirement age" (65 years of age under most plans); (2) credit years of service, salary increases, and benefit improvements which occur after an employee reaches the normal retirement age specified in the plan; and (3) not adjust actuarially the benefits accrued as of normal retirement age for an employee who continues to work beyond that age [29 CFR 860.120].

Shortly after the publication of these interpretations, the administrative and enforcement authority under the ADEA was transferred from DOL to the Equal Employment Opportunity Commission [EEOC]. The EEOC subsequently commenced a review of the factors relevant to the DOL interpretation by requesting public comments on the continuation of present practices—see, 48 FR 41436, September 15, 1983. Numerous groups and individuals responded to the request, providing the EEOC with hundreds of pages of information, most of which supported prohibiting employers from discontinuing pension benefit accruals at the normal retirement age. EEOC evaluated the public responses, and on June 26, 1984, voted to rescind the DOL opinion that accruals were not required and to replace it with a new proposal that will require continued contributions and crediting for workers past normal retirement age. The EEOC was in the process of drafting the new proposed regulations as 1984 came to a close.

Proponents of continued pension benefit accruals beyond normal retirement age have argued that the DOL/EEOC interpretations, insofar as they permit pension benefits to be frozen or suspended, are contrary to ADEA's policy promoting employment of older persons by prohibiting employer discrimination against older employees based on age alone. Reversing the 1979 interpretation would advance the individual civil rights of older employees by removing one more barrier to equal employment opportunity for older workers. From this viewpoint, freezing pension benefits at normal retirement age confers an undeserved windfall on employers. They suggest that the purpose of pension plans, to increase the retirement income of the elderly, could be furthered at little or no increased marginal cost to the employer by extending the accrual of pension benefits beyond normal retirement age.

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[7] U.S. Department of Labor, Interim Report: Studies on the effects of raising the Age Limit in the Age Discrimination in Employment Act, December 1981, p. 223.

Supporters of the current interpretations oppose any change in the status quo on the grounds that a change in the rules would cost employers an exorbitant amount of money. Employers argue that when the Employee Retirement Income Security Act [ERISA], which regulates private pension plans, was enacted, Congress unequivocally determined that retirement plans would not be required to recognize employment beyond normal retirement age either by accruing benefits or by actuarial adjustments to existing benefits. Further, they suggest that the legislative history of the 1978 amendments to the ADEA confirm congressional intent allowing reductions in employee benefits on the basis of age. If this viewpoint is correct, and the ADEA amendments were not intended to change the intent manifested by Congress at the time ERISA was passed, then legislation will be necessary to require employers to continue benefit accruals.

Opponents of the exemption of pension accruals argue that there is no cost justification for continuing the practices.[8] Furthermore, half of all plan sponsors already permit continued accrual, apparently without putting an undue strain on their plan. This is largely due to the employers' ability to fund such continued accruals over the entire length of an employee's career, spreading out the cost to make it more manageable. Also, if discontinued accruals cause earlier retirement then pension plans will be required to pay out benefits earlier and for a longer period of time. This negates any savings that might have occurred because of discontinued accruals.

2. Discrimination-Related Legislation

The second session of the 98th Congress was unique in that several legislative issues affecting older worker employment were addressed, but with almost no public attention drawn to them. One set of issues involved amending the Age Discrimination in Employment Act. The other involved legislation to restore enforcement authority for the ADEA to the Equal Employment Opportunity Commission.

(A) ADEA AMENDMENTS

The most recent amendments to the ADEA were contained in the 1984 reauthorization of the Older Americans Act. Public Law 98-459, section 11(f), amends the ADEA by extending protections to U.S. citizens who are employed by U.S. employers in a foreign country. Support for this legislation was based in part on the belief that many such workers are really an extension of the U.S. work force who should not be subject to possible age discrimination just because they are assigned abroad.

Section 12(c)(1) of the ADEA, the executive exemption, was also amended by raising, from $27,000 to $44,000, the annual private retirement benefit level for determination of exemption from provisions of the act for persons in bona fide executive or high policymaking positions.

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[8] U.S. Congress. House. Select Committee on Aging. An Analysis of the Costs of Pension Accrual After Age 65. Comm. Pub. No. 97-323, 97th Cong., 2d sess. Washington, U.S. Govt. Print. Off., 1982.

(B) EEOC ENFORCEMENT AUTHORITY

During the first 10 years after its passage, enforcement of the ADEA was the responsibility of the Department of Labor. As a result of President Carter's Reorganizaton Plan No. 1 of 1978, implemented on June 22, 1979, by Executive Order 12144, enforcement responsibility for the ADEA shifted from the Labor Department to the Equal Employment Opportunity Commission [EEOC]. The purpose of this shift was to consolidate all Federal enforcement of job-regulated civil rights in one agency.

Since the Commission first assumed responsibility for enforcement of the ADEA in 1979, the number of ADEA charges filed with the Commission has grown from 5,374 in fiscal year 1979 to 13,078 in fiscal year 1984. ADEA charges have become the fastest growing portion of the Commission's total caseload.

The number of cases actually filed in court by the EEOC under the age statute in the past 4 years is dramatically low in comparison with the number of age charges filed. In 1984, 63 lawsuits were filed, compared to 33 in 1983 and 26 in 1982. Advocates for the rights of the aging have expressed concern that the number of cases filed is too low and that the EEOC is not serious enough about its enforcement responsibilities in the area of age discrimination. The EEOC counters that limited resources prevent them from filing more lawsuits.

The EEOC's authority to enforce the ADEA was jeopardized during 1984 by a second circuit court of appeals decision in the case of *EEOC* v. *CBS, Inc.* The court ruled that the legislative veto provision contained in the Reorganization Act of 1977 was unconstitutional, thereby invalidating the transfer of enforcement authority for the ADEA. The second circuit's ruling conflicted with an earlier decision this year by the fifth circuit court of appeals in the case of *EEOC* v. *Hernando Bank, Inc.,* holding that the transfer of ADEA enforcement authority to EEOC was valid. Shortly after the second circuit's decision, the sixth circuit court of appeals in *Muller Optical Co., et al.* v. *EEOC* ruled that the transfer of authority was valid. Nearly 100 Federal district courts had considered the issue, and most of them had found the transfer valid.

On September 11, 1984, Senator Hatch, along with Aging Committee Chairman Heinz, introduced S. 2985, a bill to ratify the EEOC's ADEA and enforcement authority. On September 12, the House Committee on Government Operations' Chairman Brooks introduced H.R. 6225, a bill to prevent disruption of the structure and functioning of the Government by ratifying all reorganization plans as a matter of law. On October 1, H.R. 6225 was passed by the House, and on October 4 it was adopted by the Senate. President Reagan signed the bill into law on October 19. The new law ratifies and affirms as a matter of law all existing reorganizaiton plans, including the Reorganization Plan No. 1 of 1978, which transferred the ADEA to the EEOC.

B. THE COSTS OF EARLY VERSUS DELAYED RETIREMENT

Most of the incentives in the present pension system are directed toward early retirement. The decision to offer an attractive out to an older employee is often considered a necessary evil in order to maintain jobs for younger workers. Employers encourage early retirement by allowing better than actuarially fair benefits to be paid to early retirees. Some employers offer pension supplements to their employees which are paid to a pensioner until Social Security benefits become available. The supplements make the retirement decision an economically feasible one far before it would have been otherwise. Employers may also offer the "open window" or "golden handshake" option which offers the employee a very attractive lump-sum benefit and early pension benefit in exchange for the employee's early retirement.

Why is early retirement so popular among employers? Conventional wisdom suggests that older workers are paid more than younger workers for the same job and therefore older workers are more expensive. This rationale has frequently been used to support early retirement programs on the assumption that younger workers can be hired at lower cost to replace older workers.

1. Employment Cost Issues

Costs of older workers.—There is a dearth of empirical information to help discern whether it costs more to employ older workers than younger workers. But a general impression presists that older workers are more expensive and that high cost may be inhibiting employers from hiring or retaining them. In September 1984, the Senate Aging Committee released an information paper which examines factors related to patterns of labor costs by age and discusses direct compensation, employee benefits, turnover, training, performance, and productivity, and presents both statistical data and qualitative information.

The evidence indicates that there are some types of employment costs which vary by age, and that overall compenstion costs increase by age, largely because of increasing employee benefit costs. There is, however, no statistical evidence that direct salary costs on an economywide basis increase by age. Employee benefit costs are not usually separated by age, and individual employers do not generally make hiring and retention decisions on the basis of benefit costs. General increases in medical care costs combined with an expanding set of laws and regulations has served to focus the spotlight on employee benefit costs for older workers, and it is possible that employers will give more consideration to this issue in the future.

The belief that older workers cost more seems generally related to feelings about performance and productivity. There is no statistical evidence to indicate generally poorer performance or productivity by age, and the limited data available refutes the basic notion that older workers are less capable. However, there is a significant issue relating to maintenance of skills and training. Over time, as the nature of work changes and the skills of the employee are not kept up to date, there will be an increasing mismatch of skills to the job, leading to deterioration of performance on that specific job.

If older workers are to be cost effective, their skills must be continuously updated through training and education to assure continued productivity.

The two major conclusions of the information paper in the costs of older workers are as follows:

—It is extremely important to encourage the maintenance of skills and lifelong education to prevent older worker obsolescence and to provide individuals with the skills to compete on a fair basis for jobs within or outside of their companies. Up-to-date skills are more important than any age-related capabilities in human resource costs and older worker productivity.

—Legislative and regulatory requirements affecting employment costs for older workers should not place undue cost or administrative problems on employers. Such requirements can discourage the employment of older workers.

Medicare cost-shifting.—Employers' concerns about the rising cost of providing health insurance for older workers has been worsened by recent legislative action. In the last decade there has been an increasing trend by the Federal Government to seek ways to curb the rising costs of Medicare by shifting costs to private payors. The Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA], legislated changes in Medicare coverage for older workers. As of January 1983, employers can no longer advise workes that they are to be dropped from company group health insurance plans at age 65 because they are eligible for Medicare. TEFRA requires that company plans bear the primary insurance costs of illiness, while Medicare becomes secondary.

The TEFRA requirement will raise employer costs in two ways. First, costs will rise for employees age 65 through 69 who previously were covered by employer plans, because these plans now are the primary payer of benefits rather than supplementing Medicare. Second, employees age 65 through 69 who previously were excluded from employer health plans must now be covered if the employer offers a plan to any employees.

A report released in June 1983, by ICF, Inc., estimated that about 434,000 private sector workers age 65 through 69—about 37 percent of all private sector workers in this age group—will be affected by these changes, at a total cost to employers of about $500 million. About 286,000, or 66 percent, of these workers were previously covered by employer plans. The additional health plan costs for these workers are estimated to be about 8 percent of their total compensation costs before the amendments. In addition, about 148,000 workers who were previously excluded from coverage are likely to be covered by employer plans. The health plan costs of these workers is estimated to be about 13 percent of their total compensation costs before the amendments. The study concludes that these changes may initially reduce the demand for workers of this age by about 1 percent. Another factor not discussed in the above study is the difficulty some employers—particularly those with few employees—are having in finding adequate health insurance coverage for their older workers. This is another disincentive for those employers to hire and retain older workers.

2. Cost-Related Legislation

Two minor provisions in the Deficit Reduction Act of 1984 [DEFRA] will have some effect on the costs of employing older workers and on the costs to older workers of remaining employed longer.

(A) MODIFICATION OF WORKING AGED PROVISION

DEFRA (section 2301) modifies the working aged provision—originally included in TEFRA—such that employers must now offer group health coverage to an employee who has not reached age 65, if the employee has a spouse age 65 through 69. If such an employee elects the group coverage—versus Medicare coverage for the spouse—the employer must offer coverage that is the same as that offered to employees with spouses under age 65. In such cases Medicare would be the secondary payer, while the employer sponsored plan would be primary.

The implications of this provision for employers are relatively minor when taken alone, but when added to the effects of already existing cost factors they are significant. Now employers have yet another disincentive to hire or retain older workers—those under age 65—because if they have an older spouse the employer, rather than Medicare, is required to pay the health costs for the spouse. These added costs may encourage employers to steer clear of older workers.

(B) PENALTIES REMOVED FOR WORKING AGED

On the other side of the coin, the disincentives to older workers of remaining on their employer's health plan have been removed by DEFRA (see section 2338). Under the TEFRA provision, those employees who elected, after age 65, to remain in the employer health plan would have been penalized for not enrolling in part B of Medicare upon their 65th birthday. This penalty amounts to a 10-percent increase on annual premiums for each 12 months that the employee does not enroll after his or her 65th birthday. Since the Medicare coverage was duplicative of the employer plan there was no need to enroll in part B until after retirement—except for the stiff penalty imposed.

DEFRA waives the part B premium penalty for workers and their spouses aged 65 through 69 who elect private coverage under the provisions of TEFRA. It also establishes special enrollment periods for such workers. The waiver applies for the period during which an individual continues to be covered under an employer's group health plan.

3. Prognosis

Despite concerns among employers about the costs of older workers, the Federal Government is seeking ways of keeping older workers in the labor force. The most notable example of this is the 1983 amendments to the Social Security Act. The compromises that resulted in the Social Security Amendments of 1983 (Public Law 98-21) reflect the belief in Congress that older people are healthier today and therefore, they can continue to work longer. In the long run, older workers will be discouraged from leaving the labor force by an increase in the penalty for early retirement, an increase in the age at which full retirement benefits are paid, an increase in the delayed-retirement credit, and a reduction in the penalty on earnings after retirement.

A provision in the Social Security Agmendments of 1983 calls for the Secretary of Health and Human Services [HHS] to study the law's implications for workers who, because they are engaged in physically demanding jobs or are unable to extend their working careers for health reasons, may not benefit from improvements in longevity. A full report, including any recommendations for providing protection against risks associated with early retirement because of health reasons, is due to be submitted to Congress by January 1, 1986.

Job training.—A second thrust of the Federal Government is to provide funds for training workers to assist them in becoming more employable. The new Job Training Partnership Act [JTPA], enacted by the 97th Congress, went into effect October 1, 1983, establishing a nationwide system of job training programs administered jointly by local governments and private sector planning agencies.

JTPA establishes two major training programs: Title II for economically disadvantaged youth and adults, with no upper age limit; and title III for dislocated workers, including those long-term unemployed older workers for whom age is a barrier to reemployment. In addition, section 124(a–d) of JTPA establishes a statewide program of job training for economically disadvantaged workers age 55 or older. Governors are required to set aside 3 percent of their title II allotments for this older workers program. During the current program year, from July 1, 1984, to June 30, 1985, the older workers' set aside is funded at $56.6 million. The title III program for dislocated workers is funded for the program year at $233 million.

The older workers program under section 124 of JTPA is meant to be operated in conjunction with public agencies, private nonprofit organizations, and private industries. Programs must be designed to assure the training and placement of older workers in jobs with private business concerns. It is too early to make an adequate evaluation of the program's success with regard to older workers.

C. CONCLUSION

The decades long trend toward earlier and earlier retirement continues unabated, and there appears to be nothing on the short-term horizon that will alter that trend. The message to older workers from both private employers and the Federal Government is clear: early retirement is desirable. Protections exist for older workers to prevent and punish age discrimination, and these are important to the few who take advantage of them. But, other policies and practices provide strong disincentives to delayed retirement—such as the denial of pension credits after age 65, the prevalance of nonactuarially reduced private pension credits offered for early retirement, and lucrative early retirement widows. In the face of these policies and practices, it is unlikely that early retirement will become less popular or necessary in the near term.

Members of Congress are increasingly aware of the potential costs of earlier retirements, but nothing in the 2d session of the 98th Congress addressed this problem in any significant way. The extensions of the Age Discrimination in Employment Act [ADEA] to Americans working for U.S. firms abroad, and the liberalization of the "executive exemption," will have some beneficial effect on employment patterns of older workers, but these were probably offset in large measure by the extension of the working aged provision to aged spouses of older workers. The increased costs of health coverage for older workers, which is exacerbated by the working aged provision, could be one of the most important factors in negating any attempts by the Federal Government to discourage early retirement or reward delayed retirement. In short, it is more costly, in pure dollar terms, to provide health benefits to older workers; therefore, employers will seek ways to avoid hiring or retaining older workers.

The most significant legislation in recent years to have some potential effect on future employment and retirement patterns was the 1983 amendments to the Social Security Act. These amendments increased the costs to older employees of retiring early. Therefore, it could be presumed that older workers may decide to remain on the job longer. Unfortunately, preliminary analyses of survey data on older workers indicate that these disincentives may not affect retirement patterns in any significant way. Their net effect, if these initial studies are correct, would be merely to lower the incomes of future retirees, rather than to encourage longer work lives.

On a more positive note, the Federal Government has taken some positive steps toward improving employment opportunities for older workers. The specific older worker provisions of the Job Training Partnership Act are a step in the right direction, toward improving the skills of older workers so they can compete more effectively in the job market. When these efforts are combined with improvements in the economy and a declining unemployment rate, the future could be brighter for those older workers who desire to work and are capable of doing so.

Part II

LOW-INCOME ASSISTANCE PROGRAMS

Despite the historical emphasis on providing a reliable source of retirement income through Social Security, private pensions, and savings, public policy has long recognized the need for programs to supplement the basic incomes of those who do not qualify for earnings-related benefits or whose income from all sources is insufficient to maintain a minimum standard of living. Assistance programs have, therefore, played a vital role in assuring a minimum level of income to the poor and low-income elderly.

Two assistance programs play an especially important role in providing income support to the needy aged—supplemental security income [SSI] and food stamps. SSI is a cash assistance program that provides monthly payments to low-income aged, blind, and disabled individuals. The Food Stamp Program provides a monthly income supplement in the form of redeemable coupons, for the purchase of basic foodstuffs. Benefits are available to all low-income households based roughly on the household's ability to allocate 30 percent of its total income to food purchase.

Some public policy analysts have characterized the preceding 4 years as a period of serious change in the concept of the appropriate scope of Federal responsibility for combating poverty.[1] In the early years of the Reagan administration, the perception—as expressed by the President—that the greedy as well as the needy had become beneficiaries of the social safety net proved a powerful inducement for reducing the scope of the Federal role in social policy. In 1981 and 1982, the administration proposed a vast number of legislative and administrative changes to implement this philosophy.

However, with an intervening recession and congressional elections, the administration has been able to realize less than one-third of the cuts it has requested in low-income assistance through fiscal year 1984.[2] These have not been predominantly in programs directly affecting the elderly and the greater portion of them were enacted in fiscal years 1981 and 1982.

The last two budget cycles have been marked by a refusal on the part of Congress to take low-income assistance cuts any further than 1982 budgetary actions took them. Overall, what changes were proposed in SSI and food stamps in 1984 were not enacted, or resulted in only minor program changes. Generally, the more successful provisions were merely administrative changes, resulting in little or no program savings.

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[1] Palmer, John L., and Isabel V. Sawhill, The Reagan Record: An Assessment of America's Changing Domestic Priorities, Ballinger 1984, p. 177.

[2] Ibid., p. 186.

In 1984, SSI program expenditures actually grew, continuing the trend of the past 4 years where, despite requested cuts of 2.5 percent, spending has increased by 8.6 percent. In that same period, requested cuts in food stamps of 51.7 percent have resulted in only 13.8 percent total reductions.[3]

There are many possible explanations for congressional opposition to further cuts in low-income assistance. Basically analysts have suggested that there is a pervasive concern that further cuts would affect the deserving poor who have a legitimate need for Federal income assistance. Further, recent studies have indicated that the majority of these deserving poor are women, predominantly single heads of households or elderly women living alone, the origins of whose poverty lies in historic social problems which these individuals had no control over.

In public ruminations over the fiscal year 1986 budget, administration officials have already stated that further deep cuts in low-income assistance programs will not be sought by the administration. They have suggested instead that since the low-income programs have already paid a price, traditionally middle-income programs might be tapped in the future as a source of budget savings.

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[3] Ibid., p. 185.

Chapter 5

SUPPLEMENTAL SECURITY INCOME [SSI]

OVERVIEW

The Supplemental Security Income [SSI] Program provides a guaranteed minimum income to the Nation's aged, blind, and disabled. Enacted in 1972 as title XVI of the Social Security Act, SSI was designed to establish a uniform, national income floor to ensure the economic security of America's most needy and vulnerable groups. Just under 3.9 million people receive benefits from SSI, with maximum Federal monthly benefits in 1985 amounting to $325 for individuals and $488 for couples. SSI is financed through general revenues, and is administered by the Social Security Administration [SSA].

In 1984, SSI was the subject of significant congressional attention. Last year marked the 10th anniversary of the implementation of SSI, and the Senate Aging Committee conducted a major oversight project to evaluate the first decade of the program, and review alternative directions for its future. The committee published a compenduim of six essays analyzing various aspects of the program, and making recommendations for improvement. Simultaneous with the distribution of this publication, the Aging Committee held a hearing to examine a range of issues related to program structure and administration.

Legislatively, Congress enacted a number of program improvements as part of the Deficit Reduction Act [DEFRA] of 1984. Specifically, Congress increased the resources test for individuals from $1,500 to $2,000 and for couples from $2,250 to $3,000. These increases are to be phased in over a 5-year period, in $100 (individuals) and $150 (couples) yearly increments, respectively. Congress also specified that in collecting overpayments, the Social Security Administration may not withhold from a recipient's monthly check an amount greater that 10 percent of that individual's monthly countable income. Also, the exclusion of in-kind assistance, provided by nonprofit organizations, from countable income, established in the Social Security Amendments of 1983, was extended for 3 more years. DEFRA included a number of additional technical provisions affecting SSI.

The passage of the Social Security Disability Benefits Reform Act of 1984 (discussed in chapter 1) will also have a major impact on the SSI Program in the coming years. Because the definition of disability, and the standards for determining it are the same for SSI and Social Security disability insurance, revisions in the disability determination system will impact both programs. SSI will be particularly affected by revisions in review standards for mentally impaired recipients and applicants, given the high proportion of the SSI caseload with mental disabilities. The new law also includes a number of provisions specific to the SSI Program, such as making permanent payments pending appeal to an administrative law judge [ALJ], and another 3-year extention of section 1619 benefits, which are designed to lessen disincentives to work in the program.

In recent years, SSI payments to the aged, blind, and disabled, have been considered a major element in the social safety net, and has largely escaped the significant budget reductions accorded other means-tested public assistance programs. In 1984, this trend continued, and in fact, certain aspects of the program were liberalized. It is possible, however, that Congress will consider cancelling or reducing the 1986 SSI COLA as part of an across-the-board freeze in Government spending.

A. SSI ISSUES

SSI was created to consolidate at the Federal level three State administered public assistance programs: old-age assistance [OAA], aid to the blind [AB], and aid to the permanently and totally disabled [APTD]. Congress intended that Federal financing and administration would:

(1) Simplify administration of welfare and provide fiscal relief to the States.

(2) Provide more adequate, more uniform, and more equitable benefits.

(3) Reduce the stigma of welfare through its association with SSA and thereby social insurance.

(4) Improve incentives for the poor to seek employment; and

(5) Decrease harassment of recipients by eliminating obstrusive eligibility investigations to determine need, and doing away with lien and relative responsibility laws.

After a decade of program operation, the basic structure and purpose of SSI has not been changed in any substantial way by Congress. Legislation addressing SSI has been primarily oriented toward improving administrative efficiency, increasing intraprogram equity, and protecting former recipients of the State programs from losing benefits due to federalization.

1. ELIGIBILITY

To qualify for SSI, an individual must be 65 or over, blind, or disabled, and demonstrate need for income supplementation. Need is determined through a means test which is an evaluation of income and assets in relation to established maximum standards. In 1985, recipients cannot receive in income more than the maximum Federal SSI benefit ($325 for individuals, $488 for couples), excluding certain disregarded income. In addition to meeting the income test, assets may not exceed $1,600 for an individual or $2,400 for couples. However, in calculating assets, the value of a person's home is not counted, nor are the first $4,500 in fair market value for an automobile and the first $2,000 in equity value for household goods and personal effects. Regulations also provide guidelines for determining the countable value of certain other assets, such as burial plots and life insurance policies. Eligibility criteria for SSI are summarized below:

Basic SSI eligibility conditions

Aged	65 or older.
Blind	Vision no better than 20/200 or limited visual field of 20 degrees or less with the best corrective eyeglasses.
Disabled	A physical or mental impairment which prevents a person from doing any substantial work and is expected to last at least 12 months or result in death.
Resource limits [1]	$1,600 per individual; $2,400 per couple.
Income limits [2]	Below $325 a month per individual; below $488 a month per couple.
Citizenship	U.S. citizen or immigrant lawfully admitted for permanent residence or other residing in the United States under color of law.
Residency	Resident of the United States or the Northern Mariana Islands.

[1] Not all resources are counted in determining eligibility.

[2] Not all income is counted in determining eligibility. Also, a person may have income above the limit and possibly be eligible for a State supplement only, but the income levels vary with each State.

NOTE.—Disabled must accept vocational rehabilitation if available. Drug addicts and alcoholics must accept appropriate treatment if available.

(A) INCOME LIMITS

From a policy perspective, many have criticized the income limits as being too restrictive. The income limit for individuals ($325 a month, or $3,900 a year) in 1985, for instance, equals only 75 percent of the poverty limit for an elderly person living alone ($5,234 a year). Clearly, a large group of people whom the Census Bureau define as living in poverty are not eligible for SSI.

Second, the law requires that gifts or inheritances, which may not be readily converted into cash, be treated as income in the month they are received. For instance, if an elderly SSI recipient is given a portable radio by her grandaughter, or inherits a kitchen table from a brother who died, she must report receipt of these gifts to SSA, and their value will be subtracted from her SSI check. Many have criticized this treatment of gifts as income as a disincentive to family and community involvement in meeting the needs of SSI recipients.

(B) ASSETS LIMITS

Most restrictive, perhaps, are the assets limits, which until recently, had not been increased since 1974, despite a 119-percent increase in the Consumer Price Index [CPI] over the same period. Today, it would take almost $3,000 and $5,000, respectively, to purchase what $1,500 and $2,250 could purchase in January 1974. The fact that these limits remained the same for a decade, and have only recently been increased in only small increments, represents a serious deterioration of the adequacy of SSI over time.

Dr. James H. Schulz, professor of welfare economics at Brandeis University, criticizes the assets test in his paper, "SSI: Origins, Experience, and Unresolved Issues," which was published in the Senate Aging Committee's print "The Supplemental Security

Income Program: A 10-Year Overview." Dr. Schulz points out five major problems with the assets test:

(1) The test discourages low-income people from saving, especially as they approach old age, and encourages people to "spend down" or transfer their assets in order to qualify for the program.

(2) Since individuals have already paid taxes on the income that they save, the asset test is a form of double taxation.

(3) People who have saved a modest amount but are unwilling to give up the economic security and sense of pride provided by resources over the limits are denied assistance, even though these resources, as far as the individual is concerned, are not available for consumption purposes.

(4) Persons with large amounts of income-producing assets will not achieve eligibility in any event because the income from these assets will be credited toward achieving the income guarantee.

(5) Administration of the asset test is costly, significantly delays eligibility decisions, is subject to a large number of errors but ultimately changes the outcome of few eligibility reviews.

A specific problem associated with the SSI assets test is that it is an all-or-nothing cutoff, or "cliff" in which small differences cause individuals to be either fully eligible or ineligible. Currently, if a recipient goes over the limit even a small amount, perhaps from interest in a bank account, that person is deemed ineligible for SSI in the month or months in which there is an excess. This ineligibility usually leads to substantial overpayments, due to the fact the error is detected after the full benefits have been paid to the recipient. In essense, if an SSI beneficiary exceeds the assets limit by $10, that individual's total benefit is eliminated; rather than reduced $10.

This problem has been exacerbated by SSA's recent policy of aggressively recovering overpayments, and rarely waiving the obligation to pay back to SSA the funds overpayed. Presently, approximately 20 percent of all overpayment errors in SSI result from problems associated with bank accounts. Significantly, these errors account for about 50 percent of the dollar amount to be collected as overpayments.

Though there are significant problems with the assets test, many argue that it serves a critical purpose in ensuring that only people with few or no resources receive benefits, and that eliminating the test would create more problems than it would resolve. For instance, outright elimination of the assets test might open the program to those with limited income, but significant resources that might otherwise be converted to cash that could be used for self-support.

Other than eliminating it altogether, there are a number of methods of revising the assets test. Congress could, for instance, limit the amount of overpayment incurred by exceeding the assets limits to the dollar amount in excess. Thus, if an individual exceeded the assets test by $10, that amount would be the debt owed to SSA, rather than the entire monthly benefit. This would eliminate the hardship imposed upon individuals owing thousands of dollars for exceeding the limits by a few cents. Critics of this approach point out that it creates a double standard: An individual would have to meet the standard when applying for benefits, but could exceed the standard once eligible and remain on the program.

Alternatively, Congress could fold the evaluation of assets into an expanded income test, where assets are translated into an "income stream" over time. Assets would be totaled, and then converted into a stream of cash income, using a set of specific actuarial assumptions (such as life expectancy tables, projected interest rates) to make the calculation. Under the current structure, it is assumed an individual will consume available assets until they drop below the SSI threshold; at that point, income supplementation will begin. Under a plan to annuitize the value of assets, an individual would receive SSI income supplementation while spending down his or her resources over time. This would eliminate the problem of an arbitrary cutoff point for people who are cash poor, but happen to have some available resources. A major problem with this approach is the difficulty of designing the basic assumptions that would guide the valuation of assets over time. Further, such a change could be costly by allowing a large number of presently ineligible individuals to qualify for benefits.

2. Benefits

Criticism of the benefit structure in SSI has focused recently on the one-third reduction rule for recipients living in the home of another, and the personal needs allowance for institutionalized recipients. In January 1985, the maximum Federal monthly payment is $325 for an eligible individual and $488 for an eligible couple. The law requires a benefit reduction of one-third for those who live in another person's household and who receive support and maintenance from that person or persons. Many groups, including the 1981 National Commission on Social Security, have recommended that the one-third reduction be eliminated. It is a very complex provision to administer, and it serves as a disincentive to SSI beneficiaries to live with others. It may be counterproductive to discourage SSI recipients with mental and physical disadvantages from living with others who may be able to provide support.

Persons who reside in public institutions are usually ineligible for SSI benefits. However, if a person lives in a community care facility serving no more than 16 people, that individual can often receive SSI benefits. Residents of larger health care institutions in which Medicaid is paying for more than half of that individual's care are eligible for a maximum $25 monthly SSI benefit, which is intended to cover personal comfort items.

Two problems emerge is the area of SSI benefits for those living in institutions.

First, the 16-person limit for community care excludes residents of shelters for the homeless, and larger, shared housing arrangments for mentally impaired individuals who need assistance in daily living.

Second, the $25 personal needs allowance for residents of nursing homes has not been changed since 1974. With the inflation that has occurred in the past decade, the value of this monthly allowance has substantially eroded. Many advocates have begun calling for an increase in the personal needs allowance, claiming that this group deserves inflation-protected benefits.

3. PARTICIPATION

Despite initial projections that over 7 million Americans would participate in SSI, the total SSI caseload has never exceeded 4.5 million. Early assumptions that over 90 percent of the eligible population would benefit from SSI were proven too optimistic; in reality, a conservative estimate of the participation rate is closer to 60 percent.

Dr. Jennifer Warlick, is an analysis of the 1975 Current Population Survey, estimated SSI participation at 50 percent for the eligible aged. In a separate study employing a set of special questions regarding SSI as part of the 1980 survey of the Panel Study on Income Dynamics (an annual, longitudinal survey of 5,000 families), Richard Coe found the elderly participation rate to be 52 percent. SSA estimates that 65 to 70 percent of the eligible population participates in SSI.[1]

These low levels of participation are difficult to explain. Few surveys of the attitudes and opinions of the SSI population have been undertaken, and alternative interpretations of the problem have often been based upon anecdotal information.

Typical explanations of low participation rates in SSI among the elderly include: (a) The stigma associated with welfare; (b) very small benefit amounts for many who near the maximum income and resource limits; (c) barriers of literacy, mental and physical handicap, and access to transportation; and (d) SSI's administrative complexity, which requires a great deal of effort on the part of participants.

An attitudinal survey of SSI participants and nonparticipants, conducted by Urban Systems Research & Engineering in 1981, found that "the big problem seems to be a lack of awareness—of the availability of SSI, of the purpose of SSI, of their eligibility for SSI." Few nonparticipants had ever heard of SSI, and many of those that had could not distinguish SSI from Social Security.[2]

Low participation, and in fact declining participation, has been significant among the aged. In 1950, over 2.8 million aged received benefits from OAA. Currently, only one-half that number participate in SSI. Between 1974 and 1980, the population of the country over age 65 increased from 21.8 million to 25.5 million; yet the proportion of those over age 65 who receive SSI payments declined from 10.5 percent in 1974 to 8.7 percent in 1980. Only the District of Columbia and California showed an increase in persons over 65 enrolled in the SSI program.

In an essay on "How Effectively Does SSI Guarantee Minimum Income for the Low-Income Aged," included in the Aging Committee's 10-year overview of SSI, Dr. Jennifer Warlick argues that participation rates must be increased if SSI is to achieve its mission. How can this be accomplished, particularly given the social isolation of many of the potential recipients? One method is heightened outreach, whether through national, SSA-initiated mailings, door-to-door campaigns conducted by such organizations as the Red Cross, or the education of local advocates, service providers, and shelters operators on the availability of SSI. Another method might be for SSA to examine the current application process, and identify means of making it more responsive to the special needs of the mentally and physically handicapped. Finally, if the payment standards were raised, it is likely that some people who do not participate presently, by virtue of eligibility for only very small benefits, would be induced to apply for larger benefits.

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[1] Warlick, Dr. Jennifer L., How Effectively Does SSI Guarantee Minimum Income for the Low-income Aged? The Supplemental Security Income Program: A 10-Year Overview. U.S. Senate, Special Committee on Aging, May 1984.

[2] Worthington, Mark et al. SSI Aged: A Pilot Study of Eligibility and Participation in the Supplemental Security Income Program. Cambridge, Mass. Urban Systems Research and Engineering, 1981.

4. ELIGIBILITY OF SSI RECIPIENTS FOR OTHER PUBLIC ASSISTANCE PROGRAMS

SSI recipients often qualify for additional Federal public assistance from a variety of programs, most notably Medicaid and food stamps. The relationship between SSI and food stamps has changed over the last decade. Originally, SSI beneficiaries were prevented by statute from receiving food stamps. This exclusion was eliminated in 1977 by Congress, by virtue of the fact that it seemed inequitable that AFDC recipients, as well people whose income or assets exceeded SSI limits, could qualify for food stamps while SSI beneficiaries could not. Currently, SSI recipients can apply for food stamps in SSA district offices, where eligibility determinations are made in accordance with conventional food stamp guidelines. In California and Wisconsin, food stamps are "cashed out," or converted into cash as part of monthly SSI payments.

States are required to offer Medicaid to SSI recipients if the recipients are eligible under the State's 1972 eligibility criteria. The 1972 legislation creating SSI gave States the option of allowing SSA to determine Medicaid eligibility, if the States were willing to accept SSI eligibility as a condition for Medicaid coverage. Currently, more than half the States have SSA execute Medicaid determinations for SSI recipients. Medicaid is perhaps the most valuable ancillary Federal program for SSI beneficiaries, and adds significantly to the adequacy of SSI coverage.

Medicaid is often more important to many SSI recipients than cash benefits, and there are a number of instances in which small increases in outside income, and corresponding ineligibility for SSI, will cause the loss of Medicaid benefits. For instance, a 60-year-old woman may become eligible for Social Security widow's benefits and concurrently lose eligibility for SSI and Medicaid, while not becoming eligible for Medicare. The loss of Medicaid often far outweighs the increase in cash benefits to these individuals.

Another area of concern is the effect of assistance provided by private nonprofit organizations to SSI recipients (for example, free food from soup kitchens, subsidized electricity) on their eligibility. Advocates argue that such assistance should be excluded from countable income, particularly because it serves the emergency needs of many very low-income recipients. Also, counting this aid as income discourages charitable involvement in providing for the poor. Opponents of this policy point out that SSI is a strict, means-tested program, and to the extent applicants or recipients have available means, whether earned or provided for free, they should be evaluated against the objective standards that limit eligibility for benefits.

5. Employment and Rehabilitation for SSI Recipients

One of the foundational objectives of SSI was to create a welfare program that had the least possible disincentives to employment. At no time, however, has more than a tiny fraction of the SSI caseload received income from earnings (in December 1983, for instance, only 3.3 percent of all recipients reported earnings).

This low rate of employment is a product of a number of factors. First, SSI recipients under age 65 are by definition severely disabled, and it is difficult to find employers willing to hire them, and take care of their special mental and physical needs. Second, there are major work disincentives built into the structure of SSI. For instance, an individual may be able to secure earnings that are more advantageous than the SSI benefit, but the loss of Medicaid coverage, and the difficulty of getting employer-sponsored health insurance, more than offsets the increased income.

The Social Security Disability Amendments of 1980 [Public Law 96-265] included changes that were meant to encourage SSI recipients to seek and engage in employment. The relevant provisions, which became section 1619 of the Social Security Act, were designed to lessen the substantial disincentives to work in SSI. They include: (a) Special monthly benefits, as well as Medicaid eligibility, will continue for disabled recipients who have completed the 9-month trial work period and continue to receive earnings in excess of SSI income limits; (b) impairment-related work expenses (including medication, attendant care, special equipment) can now be deducted from countable income; and (c) money earned in sheltered workshops is now treated as earned, rather than unearned income for the purposes of calculating benefits.

The law limited these provisions to a temporary, 3-year trial period that expired on December 31, 1983. They were extended another 3 years in 1984, with the passage of the Social Security Disability Benefits Reform Act. Though definitive statistics are unavailable, it is estimated that between 400 and 500 people receive special SSI benefits and 5,000 to 6,000 recipients take advantage of extended Medicaid benefits.

The relatively low level of utilization of these special benefits offered by the 1980 amendments appears to be a product of widespread unawareness of the existence of the provisions and of the fact that employment will not automatically terminate eligibility for SSI and Medicaid.

6. Administrative Issues

One of the original assumptions justifying the creation of SSI was the notion that administration by SSA would eliminate the harassment and stigma associated with traditional, locally run welfare programs. Though SSA has eliminated some of the most embarrassing aspects of receiving welfare—such as lien and relative responsibility requirements—critics have charged that some administrative policies have created problems for recipients in the past few years.

SSA's recent policy of collecting overpayments is perhaps the most extreme example of an insensitive approach to beneficiaries. The law authorizes SSA to recover SSI overpayments by adjusting future payments, or by direct payment by the recipient. Overpayments can be waived if the individual is without fault and if recovery would defeat the purpose of the program, or be against equity or good conscience, or the amount to be recovered is so small as to impede efficient or effective administration.

Beginning in 1981, SSA launched a set of initiatives to increase their collection of SSI overpayments as part of a major Governmentwide effort to improve Federal debt management. Special debt management teams were created in the district offices, memos were issued emphasizing rapid recovery rather than waiver or writeoff, and specific regional collection quotas and performance measures were set in place.

As part of this effort, administrative instructions were revised to replace the previous policy of withholding no more than 25 percent of a monthly check with a policy of withholding 100-percent of subsequent checks until the overpayment is recouped.

Overpayment notices were rewritten to instill in beneficiaries a greater sense of urgency about repayment. Training in debt collection used materials produced by private debt collectors to teach district office personnel how to bring in maximum cash within a minimum amount of time.

SSA's policy of withholding 100 percent of future checks to recover overpayments has been severely criticized, particularly in its application to SSI recipients. Debt generated from payments to people who survive on the monthly income received from SSI is qualitatively different from debts from Government loans. Though SSI recipients are allowed to negotiate less stringent recovery schedules, many are intimidated by SSA, and agree to paying more than they can reasonably afford.

In addition to the policy of withholding 100 percent of monthly checks to recover overpayments, SSA also instituted a policy of limiting waivers of overpayments in SSI. This change is reflected in the fact that prior to 1981, SSA waived 40 to 50 percent of all SSI overpayments; by fiscal year 1982, SSA was waiving on 13 percent of SSI overpayments. SSA also proposed new rules in February 1983 to limit the rights of recipients to request a waiver of an overpayment to within 60 days of the notification of the overpayment. These proposed rules never became final regulations, due to public opposition. Nonetheless, the proposed regulations, like the policy of 100-percent withholding, represent a change in attitude about the needs of the SSI population, and the basic mission of the agency.

B. SSI LEGISLATION

The most significant piece of SSI legislation introduced in 1984 was the SSI Equitable Improvements Act, introduced in the House by Congressmen Stark and Ford [H.R. 5347] and in the Senate by Senators Moynihan, Heinz, and Glenn [S. 2569]. The legislation was made up of almost 30 specific provisions which addressed a broad variety of complex and detailed problems in the program.

A key objective of the legislation was to simplify administration of the program while improving benefits to recipients. For instance, one provision would exclude interest income from being counted against the assets limitations in order to prevent small increases in interest on savings (usually $10 or less) from making recipients ineligible for benefits. SSA estimated that administrative savings created by this change would offset any new expenditures. Another provision would make permanent the exclusion from income of emergency in-kind assistance provided by private, nonprofit organizations.

A second goal of the bill was to update the assets limits and certain benefit standards that had not changed since the inception of the program. The legislation called for an increase in the assets limits from $1,500 for individuals to $2,000 and from $2,250 for couples to $3,000. It also would have increased the personal needs allowance from $25 to $35 a month, and index those benefits to the CPI thereafter.

The legislation included provisions to establish more reasonable and flexible guidelines in assessing and collecting overpayments. In cases not involving fraud, SSA overpayment recoveries would be limited to a rate no greater than 10 percent of the individual's total benefits per month. The bill also called for a limitation on the amount of overpayment incurred when the amount of excess resources is small. For instance, if a recipient's bank account exceeds the limit by $10 a month, the overpayment collected would be $10, rather than the entire check for that month.

The legislation included provisions to correct unintended consequences in the structure of the program. For example, the bill would exclude the value of gifts or small inheritances from calculation of income in the month received if in the following month the items would be excluded as a resource. A piece of inherited furniture or kitchen equipment received as a gift is normally exempt from the assets test as a household good in the following month, but is considered as countable income in the month received.

Finally, the SSI package included a number of provisions to improve access to the program to potential recipients, and upgrade administrative practices. For instance, the bill would mandate SSA to improve the clarity, simplicity, and completeness of notices to recipients. It would require SSA to continue and expand outreach efforts called for by the Social Security Amendments of 1983. It would also direct SSA to provide special assistance to mentally and physically disabled applicants and recipients, to ensure that they are not discouraged from participating because of their impairment.

Though neither the House or the Senate acted directly on H.R. 5347 or S. 2569, sections of the SSI package were included in larger legislative vehicles. The House included sections of the SSI bill in H.R. 5394, a large spending reduction package, which was passed on April 12. No similar measures were included in the Senate deficit reduction bill. However, most of the SSI provisions were agreed to in conference and passed in the final version of the Deficit Reduction Act of 1984 on June 27. The following SSI provisions were included:

Increase SSI resources limits.—The ceiling on countable resources, now set at $1,500 for an individual and $2,250 for a couple, will increase over the next 5 years to $2,000 for an individual and $3,000 for a couple. During the 5-year period, the allowable resource level for an individual will increase by $100 each year; for an eligible couple, by $150 each year. The $1,500 and $2,500 figures have not changed since SSI was enacted in 1972.

Limit the rate of overpayment recovery.—Except in cases of fraud, SSI will not be permitted to recover more than 10 percent of an SSI recipient's total income each month in attempting to recoup an alleged overpayment. Current SSA practice is to withhold the entire SSI check to someone with no other income.

Limit amount of overpayment to the excess over resource ceiling.—Currently, if an SSI recipient accumulates resources that take him or her over the $1,500 limit, the entire amount of the benefit is an overpayment—even if the person's resources were only $10 over the limit. The bill limits the amount of the overpayment to the amount over the resources limit in cases where the excess is less than $50, and does not involve fraud.

Exclude retroactive SSI or OASDI checks from resources for a year.—When an SSI recipient receives a retroactive SSI or OASDI benefit check, it will not be treated as a countable resource for 6 months. This period will permit the person time enough to plan how best to use the funds without jeopardizing current eligibility.

Emergency assistance from nonprofits excluded from income.—The 1983 Social Security Amendments provided that emergency and other noncash assistance provided by a private, nonprofit organization to an SSI applicant or recipient will not be counted as income if it was provided on the basis of need. This provision was extended another 3 years to October 1, 1987.

Following the inclusion of parts of H.R. 5341 into the House deficit reduction package, the Subcommittee on Public Assistance and Unemployment Compensation held a hearing on the remaining sections of the bill on May 9. On May 17, the Senate Aging Committee held a hearing on "A 10th Anniversary Review of the SSI Program," and though broad in scope, the hearing did focus some attention on the provisions in S. 2569. The Senate Finance Committee held no hearings on the subject, nor did it ever actively consider S. 2569 in 1984.

In September, the House took up the remaining provisions of H.R. 5341. The Subcommittee on Public Assistance and Unemployment Compensation marked up the bill on September 13, and reported to the full Ways and Means Committee H.R. 6266, a new bill that included both the SSI provisions and foster care legislation. H.R. 6266 was subsequently reported to the House by the Ways and Means Committee. It passed the House on October 1.

In the Senate, the foster care provisions were stripped off H.R. 6266 and passed on another vehicle. The SSI amendments were not taken up in the Senate before the end of the 98th Congress, due to the opposition from the administration, and the chairman (Senator Dole) and ranking minority member (Senator Long) of the Finance Committee.

C. PROGNOSIS FOR SSI IN 1985

In 1985, it is possible that Congress will put a freeze on SSI payments by cancelling the 1986 COLA. In the face of mounting Federal deficits, SSI may not be exempted from cuts as it had been in the past, particularly if support is garnered for an across-the-board budget freeze requiring sacrifices in all areas of Federal spending. Alternatively, the SSI COLA could be left intact, in order to protect low-income aged, blind, and disabled people, or perhaps a reduced COLA could be provided to guarantee at least partial protection against inflation. Other than an across-the-board COLA freeze, it is unlikely that Congress will substantially modify SSI through more specific benefit cuts.

What would be the effect of a 1-year freeze on the SSI COLA? Initially, it would amount to a direct cut in benefits of 3 percent, 4 percent, or whatever the 1985 CPI increase equals. A 3.5-percent COLA cancellation would amount to a loss of $137 for individuals and a $205 loss for couples in 1986. Second, it would lower the base upon which future COLA increases are calculated, and thus result in a permanent deterioration of SSI benefits in relation to the poverty limit.

Next year, there will likely be interest in enacting some of the provisions included in H.R. 6266. The provision with the greatest political support—and cost—is the increase in the personal needs allowance from $25 to $35 for institutionalized SSI recipients. The strongest support for H.R. 6266 in the Senate was generated by this provision. The administration has opposed this change because it would increase SSI and Medicaid costs. The increase in Medicaid costs is caused by the fact that non-SSI Medicaid recipients would have their personal needs allowance increased as well in order to ensure that all institutionalized Medicaid recipients receive the same monthly amount. If this equivalence is not maintained, SSI institutionalized individuals would receive more in monthly benefits than other institutionalized individuals, including Social Security beneficiaries.

Overall, in the past 4 years, SSI has been exempted from social spending cuts, and has maintained preferred status among public assistance programs. In the next few years, as Congress searches for ways to cut the budget, SSI may be scrutinized more closely, particularly in the context of an across-the-board freeze in Federal spending.

Chapter 6

FOOD STAMPS

OVERVIEW

Throughout 1984, the Food Stamp Program was the subject of considerable controversy and debate, due to a broad range of hearings and reports making alternative recommendations for the program. This is a program of tremendous importance to the low-income elderly even though the elderly are estimated to account for only 8.5 percent of the 21.4 million food stamp participants. Issues of particular interest to Congress were the accessibility of the program to the eligible population, the adequacy of the benefits provided, and the degree to which States should assume responsibility for program costs and administration.

Although considerable media attention was focused on the issue of hunger in 1984 by hearings and commission reports, generally speaking, Congress persisted in its reluctance to deal substantively with the Food Stamp Program. Only one bill, the Hunger Relief Act of 1984 [H.R. 5151], was the subject of congressional activity in 1984. It would have provided small benefit increases, liberalized several rules governing eligiblity and food stamps, and required increased State responsibility for paying for erroneous benefits. This bill was approved by the House in August 1984; the Senate, however, declined to review or act upon this legislation, and it died with the end of the 98th Congress. In the end, two minor changes in the Food Stamp Program were incorporated in two omnibus bills, The Deficit Reduction Act [Public Law 98-369] and the 1985 Continuing Resolution [Public Law 98-473].

The Deficit Reduction Act contained provisions giving the Food and Nutrition Service [FNS] access to Internal Revenue Service information concerning food stamp recipient's income, and allowing the FNS to recoup overpayments by intercepting tax refunds. These changes were drawn from recommendations made by the Private Sector Survey on Cost Control in the Federal Government [the Grace Commission]. The Continuing Resolution contained a provision that reversed a 1-percent across-the-board decrease in food stamp benefits enacted in 1982. Effective November 1984, food stamp benefits will be calculated on the basis of 100 percent of the Agriculture Department's "Thrifty Food Plan," rather than 99 percent.

In addition to these changes, Congress approved a $700 million supplemental appropriation for fiscal year 1984 in August [Public Law 98-396]. This brought total 1984 funding to $12.4 billion. In October 1984, the fiscal year 1985 Continuing Resolution enacted a $12.3 billion funding level for food stamps.

A. FOOD STAMPS ISSUES

In the past 4 years, the Food Stamp Program has been the source of substantial budget savings due to cuts enacted by Congress, and administrative changes executed by the administration to limit fraud and abuse in the program. Overall, the Congressional Budget Office [CBO] has estimated that these measures will hold food stamp spending down for fiscal 1982 through 1985 by nearly $7 billion (or 13 percent) below what would have been spent under the pre-1981 law. Though the changes did not lead to a direct reduction in benefits for most food stamp recipients, they did delay or lower benefit increases scheduled under previous law. However, about 1 million people did lose eligibility for food stamps, and some recipients have received reduced benefits due to administrative revisions.

With this background in mind, debate in Congress has focused on whether the program has been cut too far, and needs to be expanded, or whether further savings in the program are justified. Framing this debate are alternative assumptions about the extent of hunger in the United States, and the role of food stamps in combating it. In 1984, these issues were addressed in a number of hearings and reports, and a variety of recommendations were made to change the program.

1. The Administration's 1984 Proposals

As part of its fiscal year 1985 budget presentation to the Congress in February 1984, the administration proposed three basic legislative changes in food stamp law aimed at holding fiscal year 1985 spending nearly $600 million below what would be spent under present law.

The major revision would be to decrease the Federal responsibility for the cost of erroneous benefits by transferring a portion of this cost to the States; this change accounts for about $500 million of the total gross savings anticipated. A second proposal, expected to save some $85 million, would require States to operate workfare programs in which able-bodied adult food stamp recipients would have to work off the value of their household's benefit in public service employment. A third proposal, anticipated to save $4 million as the result of reduced errors, would slightly simplify food stamp eligibility determinations by making most recipients of Aid to Families with Dependent Children [AFDC] Program automatically eligible for food stamps. Certain administrative and technical changes were also proposed.

(A) ERRONEOUS BENEFITS

Erroneously issued food stamp benefits (overissued to eligible households and benefits issued to ineligible households) are estimated to be running at 8.5 percent of benefit costs, costing the Federal Government nearly $1 billion annually. The Food Stamp Act requires the Federal Government to pay for benefits and for about half the cost of State and local administration; actual day-to-day administration, using federally prescribed rules, is the responsibility of State and local welfare offices. States and localities pay half their administrative costs. Error rates vary substantially from

State to State, from over 20 percent in some cases to well under 5 percent in others. Present law sets a 5-percent error rate as the goal to be reached by each State in fiscal year 1985. If a State fails to meet this objective, it faces a penalty of loss of some of the Federal share of administrative expenses.

In place of this system, the administration has proposed that States be required to pay a portion of the actual cost of erroneously issued benefits. Under the administration's plan, the Federal Government would pay the cost of erroneous benefits up to 3 percent of total benefit costs in a State; the cost of erroneous benefits above 3 percent would be a State responsibility. In effect, the proposal would lower the target error rate immediately and substantially, from 5 percent to 3 percent. It would also significantly increase the penalty States must pay for erroneous benefit issuance.

The administration's proposal reflects the assumption that States need greater incentives, in the form of stronger sanctions, to improve their administrative performance. Lower error rates in programs which require State contributions to the cost of erroneous payments, such as AFDC, is cited as evidence for this assumption.

Critics maintain that State treasuries are ill-prepared to take on the added burden of significant food stamp benefit costs masked as an incentive for better administration, and argue that the existing error-rate reduction system (only recently put into place) has not been given a chance to prove itself. They contend that high error rates are, to a substantial degree, the fault of the Federal Government's regulations and overlegislating the program. Further, they are worried that overzealous administrators would deny benefits to those really eligible, or underissue benefits in an effort to ensure lower error rates and a smaller penalty, and that States might cut back on other welfare spending in order to pay any necessary food stamp penalties.

(B) WORKFARE

Under present law, States and localities may choose to operate food stamp workfare programs, under which unemployed or under employed able-bodied adult food stamp recipients not caring for very young children or the disabled are required to work off their household's food stamp benefit in a public service job in order to retain eligiblity. The cost of operating workfare programs is shared by the Federal Government and the operating jurisdiction, and if a benefit savings results because the workfare participant gets a job, a part of the savings is returned to the operating jurisdiction. However, very few jurisdictions now choose to operate food stamp workfare programs.

The administration proposed that States would have to provide workfare slots for at least 75 percent of covered individuals, and several other changes would be made in the existing workfare law. This proposal, rejected in the 97th Congress and again in 1983, is recommended as a method to control abuse of the program by those who are able, but who are unwilling to work, and to get needed public service jobs done. It is also seen as a way to improve the image of the Food Stamp Program, and increase support for it, along with benefiting recipients by giving them work experience.

However, opponents note the significant cost of operating workfare programs and the lack of response to the present optional authority (only 11 local jurisdictions now operate workfare programs under Food Stamp Act authority). They also question whether benefit savings would outweigh administrative costs and contend that the existing system has not been given time to demonstrate the effectiveness (and flaws) of workfare.

2. The Grace Commission Recommendation for Food Stamps

Throughout the spring of 1983, the Agriculture Department task force of the Grace Commission issued a series of recommendations for changes in the Food Stamp Program that could achieve significant savings. Although they are not official administrative proposals, they have not entered the debate over the potential budget reduction initiatives for the Food Stamp Program.

This effort was part of a governmentwide set of task force reviews focused on producing new ideas for cost control. The set of specific recommendations for food stamps described here would, if all were implemented, achieve savings estimated (by the task force) at $1.9 to $2.1 billion annually. Other Commission suggestions affecting multiple programs, including food stamps, would increase the use of IRS information in verifying recipient income and assets and allow tax refunds to be intercepted to repay overissued benefits.

The major recommendation of the Grace Commission task force was to revise the method by which food stamp allotment levels are established. Maximum monthly food stamp allotments are now based on the costs of purchasing food using the Agriculture Department's least costly food plan—the thrifty food plan. The thrifty food plan amount for a standard four-person family (husband, wife, and two school age children) is established and maximum allotments for other household sizes vary from that amount according to a formula reflecting economies of scale. Actual benefit allotments vary from the household maximums only to the extent the houshold has countable income.

The Grace Commission recommendation would require that the age, sex, and household size composition be considered in choosing the appropriate thrifty food plan amount on which to base benefits. For example, rather than use the standard four-person family as a base, use the average three-person food stamp household. In addition, the task force recommended an administrative revision of the economies-of-scale formula used to set benefit levels for household sizes other than the base household, reducing allotments for small households and raising them for large ones.

Revising the thrifty food plan base used for establishing food stamp benefit levels was put forward with the justification that food stamp benefit levels should reflect the composition of the population served. Critics of this change would argue that adequate diets are very difficult to achieve using the current benefit levels, and would be much more so with the reduced levels that would result for small households from the recommended revisions.

The other major recommendation of the Grace Commission would require that the value of the Federal subsidy in school lunches and meals provided in other federally supported child nutrition programs be counted as income to a food stamp household receiving them, thereby increasing the households counted income and reducing its food stamp benefits to the extent it participates in child nutrition programs. At present, the Food Stamp Program counts only cash income received directly.

Counting Federal child nutrition subsidies as income was advanced as a way of eliminating program duplication. However, it would reduce what are seen by some as already inadequate benefits to families with children, and add administrative burdens and potential new inequities to the Food Stamp Program.

3. The President's Task Force on Food Assistance

At the end of January 1984, the President's Task Force on Food Assistance released its report to Congress and the public. Although the report acknowledged pockets of hunger, it asserted that there was little evidence of widespread hunger. Several modest recommendations to make the Food Stamp Program more accessible to the hungry were included in the report.

These included:

—Liberalized rules governing liquid assets and car ownership.

—Targeted benefit increases to beneficiaries with high medical or shelter expenses (particularly the elderly and disabled).

—Automatic food stamp eligibility for cash welfare recipients, (including those on SSI).

—Modification of the permanent residence requirement so that benefits are available to the homeless.

These liberalizations were balanced off against cost-reduction measures which included:

—Increasing the State responsibility for erroneous payments over 5 percent of benefits issued.

—An optional State block grant for food assistance.

The task force recommendations have been heralded as a means of restoring full benefits, opening up the program to the new poor (the recently unemployed), lessening administrative burdens, and increasing participation among groups in particular need (the homeless and the elderly). However, critics have contended that the task force recommendations do not go far enough in restoring budget reductions previously enacted. These critics have opposed both the proposal to make States pay a portion of the cost of erroneous benefits and the optional block grant proposal.

4. The Kennedy Report

In December 1983, Senator Edward Kennedy issued to the Senate Committee on Labor and Human Resources a report entitled "Going Hungry in America." Based on a field investigation undertaken the week before Thanksgiving 1983, Senator Kennedy's report found that hunger was on the rise in America, and that Congress must act to improve assistance to the hungry.

The Kennedy report contained seven suggestions for change in the Food Stamp Program, with an estimated annual Federal cost of $2 billion. The intent of the recommendations made in the report was to restore several of the major food stamp budget cuts legislated in 1981-82 and significantly increase basic food stamp benefits.

Senator Kennedy's major proposal (accounting for $1.7 billion of the overall $2 billion cost) would restore the 1-percent allotment reduction legislated in 1982 and add a 10-percent benefit increase to take into account a percent that existing food stamp benefits, even at 100 percent of the thrifty food plan, do not allow for purchasing an adequate diet in the real world of transportation difficulties, price variations, limited nutritional education, and other limits that reduce a family's ability to purchase food. In addition to opposing the substantial cost involved in this proposal, critics point out that the Food Stamp Program is designed to supplement a household's food-buying power and cannot be expected to bear the burden of correcting for other non-food-related income problems.

5. OPTIONAL BLOCK GRANTS

One issue that has been the subject of considerable controversy in the past few years is the idea of allowing States the option of receiving an annual block grant to meet the nutritional needs of its low-income population, in lieu of operating the Food Stamp Program. A State choosing a block grant would be entitled to a percentage share of each fiscal year's overall food stamp appropriation equal to the share it had of the Federal funds spent on food stamps. Under the block grant, a State would be free to design and operate a low-income nutritional assistance program of its own choosing, as Puerto Rico is now doing, with very few federally prescribed rules. It could choose what persons to assist, with what kind and what level of benefits.

Proponents of optional block grants as a replacement for the Food Stamp Program argue that they would improve administration of nutritional assistance benefits by freeing States from burdensome Federal rules that may or may not fit the needs of a State's low-income population and by indirectly giving States a financial stake in the quality of administration.

Opponents point to the Food Stamp Program's role as a gap-filler, providing aid to low-income groups not served by State welfare programs, and providing benefits in relation to need, as reflected in the participation rates. They fear that with fixed block grant allocations, States would not be able to provide the same levels of assistance to the same segments of the low-income population, especially when economic downturns required increased spending. The Congress might respond to economic conditions with a legislated increase in total nationwide food stamps but these increases might not be responsive to State-specific conditions.

6. RESTORING THE PURCHASE REQUIREMENT

Some in Congress have recommended the restoration of the food stamp purchase requirement for all participating households except the elderly and disabled. Prior to 1979, food stamp participants were required to pay a portion of their monthly income in order to receive benefits. Each recipient household got the maximum allotment for their household size, paid a portion of their counted income into the program (when their stamps were issued to them), and received, as a benefit, the difference between their contribution (the purchase requirement) and the value of the total stamp allotment issued to them.

Elimination of the purchase requirement increased participation in the program by granting benefits to eligible households that were unable or unwilling to buy food stamps. Proponents saw the elimination of the purchase requirement as the removal of an artifical barrier to participation by those in need. However, opponents of elimination saw the purchase requirement as a way of limiting assistance to those needy enough to be willing to commit some of their own resources to food purchases and as a way of maintaining the nutritional orientation of the program.

B. FOOD STAMPS LEGISLATION

1. The Hunger Relief Act of 1984

The major source of legislative activity in 1984 centered around H.R. 5151, the Hunger Relief Act of 1984. Introduced by Representative Leon Panetta in response to concern that hunger was increasing in America, the original bill contained a comprehensive set of proposals changing food stamp rules, revising the Commodity Supplemental Food Program, continuing the emergency feeding program operated by private charities and the Federal Emergency Management Agency (FEMA), expanding surveys monitoring the nutritional status of the low-income population, and providing grants to States to enhance nutritional education efforts.

The changes proposed for the Food Stamp Program would significantly increase benefits, liberalize certain eligibility rules, allow for expanded outreach and job assistance efforts, and make revisions intended to simplify State administration of the program. Preliminary estimates suggest that, taken together, the food stamp provisions of the bill would have resulted in added Federal costs of over $1 billion in fiscal year 1985, and about $1 billion annually in later years.

In May 1984, the House Agriculture Committee reported out a substantially amended version of H.R. 5151. A bipartisan compromise, the bill included the benefit and eligibility liberalizations recommended by the President's task force, several additional benefit increases (including increases for the elderly and disabled), and a requirement that States begin picking up a larger share of the cost of erroneous benefits beginning in 1986. The net cost was estimated at $300 million in 1985, as opposed to the $1 billion cost estimate of original H.R. 5151.

On August 1, 1984, the House passed H.R. 5151. Its passage was attributed to the fact that it was a compromise package, made up of benefit increases, administrative simplification measures, and cost-controlling initiatives.

The Hunger Relief Act of 1984 ultimately died in the 98th Congress, however. The Senate declined to consider the measure before adjournment.

2. Legislative Changes

The Deficit Reduction Act of 1984 incorporated two Grace Commission recommendations increasing the role of the IRS in the administration of welfare, food stamp, and other programs. These provisions: (1) expanded the ability of State welfare offices to verify recipients' income and assets by making IRS information available and requiring its use; and (2) permitted the Federal Government to intercept income tax refunds to recoup overpaid benefits. Opponents of the measure argued that it invaded the privacy of the beneficiaries, and increased the opportunity for unjustified interference in their finances. These provisions are expected to produce some $90 million in Food Stamp Program savings over the next 3 years, plus added savings in other welfare programs.

Recognizing the likelihood that there would be no Senate action on the House-passed version of H.R. 5151 before the end of the 98th Congress, the House chose to add one major provision of the bill to the fiscal year 1985 Continuing Resolution (H.J. Res. 648), through a floor amendment on September 25, 1984. The provision it chose to add was a restoration of the 1-percent benefit reduction, effective November 1984.

The Senate followed suit in its version of the continuing resolution and, with enactment of the resolution [Public Law 98-473] on October 12, the across-the-board 1-percent benefit increase became law. Beginning with November 1984 benefits, it meant increases ranging from $1 to $5 per household per month.

3. Appropriations

For the first time in 2 years, appropriations under the continuing resolution for the next fiscal year were made according to a best estimate of full program costs creating at least the possibility that no 1985 supplemental appropriation will be needed. Although there is some concern that the added 1-percent benefit might necessitate some small supplemental appropriation, it is far from the situation in the past 2 years when appropriations have been set below projected program costs.

In fiscal year 1984, appropriations had assumed benefit cuts which were never enacted by the Congress and resulted in the necessity for a $700 million supplemental appropriation for the Food Stamp Program [Public Law 98-396] in August. In fiscal year 1983, an unexpectedly large increase in unemployment rates had led to a shortfall of $1.2 billion. With benefit cuts only weeks away supplemental appropriations which were finally approved in last minute action by the Congress just before its August recess [Public Law 98-63]. Participant interest groups had become concerned in recent years that the pattern of stalling action on supplemental appropriations might become a yearly phenomenon, to the detriment of dependent beneficiaries.

C. FOOD STAMPS REGULATIONS

Beginning in 1983, the administration undertook a complete rewrite of most food stamp regulations with the aim of simplifying them and tightening rules governing receipient and State agency responsibilities (such as verification of household circumstances). Although this revision of food stamp regulations has not been (and may not be) formally proposed, several drafts were released in the early spring of 1984 and provoked criticism. The draft most recently released to Congress (on February 23) brought the criticism that it would hurt low-income families by reducing some recipients' benefits and increasing application burdens, and that it would complicate program administration by requiring another change in State and local food stamp administrative procedures after 4 years of frequent changes.

Many Members of Congress expressed dissatisfaction with the draft regulation changes. Senator John Heinz, chairman of the Aging Committee wrote to Secretary of Agriculture John Block, arguing that the "proposed revisions appear to pose serious disincentives to participation by the elderly" in the Food Stamp Program. Senator Heinz recommended that the draft regulations be shelved until Congress considers the reauthorization of the Food Stamp Program in 1985.

Linked to this congressional interest in the food stamp draft regulations is a concern that the Department may, by regulation, change the economies-of-scale formula used to set basic food stamp benefit levels (see earlier discussion under Grace Commission proposals). As a result, the committee reports accompanying the House and Senate versions of the fiscal year 1985 food stamp appropriation [H.R. 5743, H. Rept. 98-809, and S. Rept. 98-566], incorporated into the fiscal year 1985 Continuing Resolution, direct that the formula not be changed by regulation and that the Department await legislative consideration of the issue. The committee report accompanying H.R. 5151 [H. Rept. 98-782] also includes such language.

D. PROGNOSIS FOR FOOD STAMPS IN 1985

Given that the authorization for food stamp appropriations expires at the end of fiscal year 1985, as do the authorizations for most farm programs, major food stamp legislation as part of a 1985 farm bill is likely in 1985. This reconsideration will likely be comprehensive in light of the continuing interest in the program, and the broader need for reductions in Federal expenditures. Proposals that were not enacted in 1984 will likely resurface, in addition to those raised by the Grace Commission, the President's task force, and the FNS regulation rewrite. It seems unlikely that benefits or eligibility requirements will be either greatly expanded or reduced next year, due to pressures of the budget deficit on the one hand, and the sense that hunger has increased on the other.

Part III

HEALTH

More Americans are living longer than ever before in our Nation's history. This increased longevity means more healthy years, but also more years of poor health.

The most important factors affecting the increases in longevity are the decline in death rates and the general improvement in health status for the elderly. These have occurred because of an historical commitment in America to fund biomedical research, provide adequate health services, and assure adequate coverage for health costs. This national commitment has been unevenly implemented, but significant strides have been made in all these areas over the past several decades.

Recently, however, Federal attention in health care has been focused almost exclusively on efforts to control increases in health expenditures. Health care now consumes over 10 percent of the gross national product, and the disparity between the very slow rate of growth in the economy and the continued, rapid rate of growth in national health care costs has created a near-panic atmosphere.

Of particular concern to older Americans and to the Congress is the future of Medicare. The most recent estimates predict insolvency of the hospital insurance trust fund by 1994. This year, Medicare insured over 28 million older Americans for health care—at an estimated cost of $63 billion. Medicare has become the second most costly Federal domestic program, exceeded only by Social Security. And, as a steadily increasing share of the total Federal budget, it has become the target of a number of cost-saving measures proposed and enacted over the past few years. In 1983, Congress enacted legislation to control increases in hospital expenditures, Medicare's prospective payment system. In 1984, Congress enacted the physician fee freeze to begin to slow down the increases in part B expenditures. Congress has also considered and enacted a number of proposals to increase beneficiary out-of-pocket costs for health care.

Since its enactment, Medicare has paid a steadily increasing share of the health care costs of the elderly. Nonetheless, the elderly still pay a substantial part of health costs directly. In fact, the elderly now spend, on average, as large a share of their incomes for health care as they did before the enactment of Medicare. For low-income medicare beneficiares not covered by Medicaid, the share of income spent on health care is particularly high. According to the Health Care Financing Administration, in 1984, elderly persons paid on average $1,059 out-of-pocket for health care. While the administration and the Congress have and will continue to consider measures to maintain the solvency of the HI trust fund and to slow the rate of increase in SMI expenditures, proposals that shift costs to beneficiaries may jeopardize the economic security of older persons and their families.

The promise of Medicare to assure older Americans access to quality health care without fear of impoverishment seems to be threatened on another front by a major uninsured but not unlikely risk: long-term care. According to Senator John Heinz, Aging Committee chairman, "The potential cost of long-term care service represents the single greatest threat to the economic security of all but the wealthiest or the poorest." During 1984, however, not a single legislative proposal was enacted to improve either access to or coverage for long-term care. While the need for additional long-term care services is well documented, the potential cost of providing them seems to have dampened congressional interest or action for this issue for the foreseeable future.

Chapter 7

HEALTH CARE

OVERVIEW

Today, nearly every older American has some coverage for health care costs. Most, approximately 28 million persons, are insured by the Medicare Program. Of that 28 million, 3.3 million persons are covered by Medicaid. While there is some variation from State to State, Medicaid typically buys into the Medicare Program by purchasing premiums and deductibles for low income dually eligible persons. In addition to Medicare and Medicaid coverage, nearly 7 out of every 10 older Americans have supplemental medical insurance policies.

With improved access to better health coverage has come simultaneous and dramatic increase in health costs. Since the early 1960's health care costs have been exploding with annual increases in costs at multiples of the increase of the Consumer Price Index. The result has been a doubling of the proportion of the Nation's resources devoted to health care. In 1960, 24 years ago, 5.3 percent of the GNP was spent on health care. Today, 10.5 percent of the GNP goes into health care.

For the past decade or so, Federal and State policymakers have made repeated attempts, with limited success, to gain control over rising national health care costs—in particular to control the increasing expenditures for Medicare and Medicaid. More recently, concern about the need to control health care costs has spread beyond Government circles. Large employers, as purchasers of health insurance, and labor union leaders, as representatives of many working insured, are now attempting to control the cost of insurance and fringe benefits; health costs now threaten to erode health coverage for current and retired employees.

In the absence of broad reform of the health care delivery system, there will be continuous and mounting pressures from all sectors to slow the rate of increase of health expenditures.

A. HEALTH CARE COSTS

In recent years, there has been a particularly alarming disparity between the very slow rate of growth of the economy and the continued rapid rate of growth in national health care costs. Between 1979 and 1982, real GNP increased cumulatively by less than ½ of 1 percent, while real national health care expenditures increased cumulatively by nearly 13 percent and real Medicare expenditures increased cumulatively by nearly 28 percent [table 1]. This rapid growth in inflation-adjusted spending for health care relative to our country's ability to pay has created a general sense of urgency to bring costs under control.

TABLE 1.—ANNUAL PERCENT CHANGE IN REAL (INFLATION-ADJUSTED) GROSS NATIONAL PRODUCT, HEALTH CARE SPENDING, AND MEDICARE BENEFITS: 1980–82

Item	Percent change from previous year			Cumulative growth 1979–82	Price deflator used
	1980	1981	1982		
Gross national product [GNP]	−0.3	2.6	−1.9	0.4	Implicit price deflator for GNP.
National health expenditures [NHE]	4.6	4.4	3.2	12.7	Implicit price deflator for NHE.
Community hospital inpatient services	5.0	5.7	5.5	17.1	National hospital input index.
Total Medicare benefits	9.5	9.4	6.8	27.9	Implicit price deflator for personal health care expenditures.
Medicare hospital benefits	9.7	7.8	5.9	25.2	National hospital input price index.
Medicare physician benefits	8.6	12.3	7.3	30.9	Consumer Price Index for physicians' services.

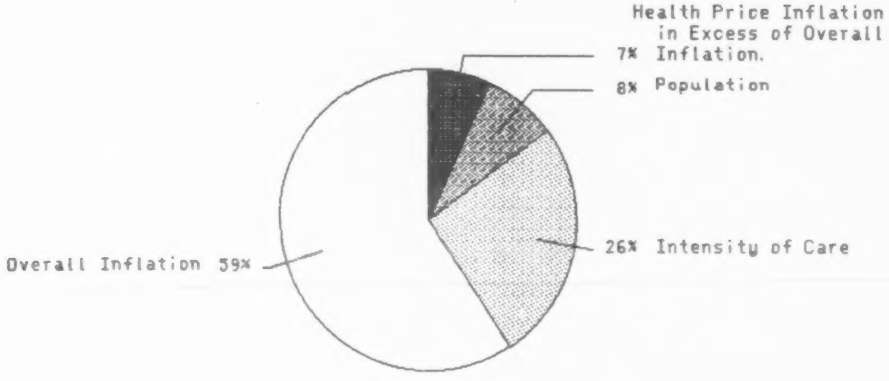
Source: Health Care Financing Administration, Bureau of Data Management and Strategy, Office of Financial and Actuarial Analysis.

The increase in national health expenditures is attributable to four factors: (1) Economy-wide inflation, (2) population growth, (3) health price inflation in excess of overall inflation; and (4) an increase in the type and mix of services provided per patient, often referred to as increases in intensity of care.

Chart 1 shows the relative contributions of these four components to the increase in national health expenditures between 1972 and 1982. Of the two components that are health industry specific, intensity of care accounts for almost four times as much of the increase as the inflation in health care prices above general inflation.

CHART 1

Factors Accounting For Growth In
Total National Health Expenditures:
1972-1982



1972-82

SOURCE: Health Care Financing Administration,
Bureau of Data Management and Strategy,
Office of Financial and Actuarial Analysis.

1. Sources of Health Care Cost Increases

The major contributors to health care cost increases, apart from inflation, are the factors that contribute to the increased intensity of care.

(a) One factor is the traditional piecework payment methods used by third-party payers, that is, fee for service payments for physicians and cost-based reimbursement for hospitals. These payment methods contain incentives to physicians and hospitals to provide more rather than less care and also to provide the most expensive forms of care. To the extent that physicians and hospitals are motivated by these incentives, intensity of care is increased. Sometimes, third-party payers establish limits on the amounts they will reimburse, but total costs may still not be contained because the physician or the hospital may pass the unreimbursed costs on to other third-party payers or to patients who must pay the additional costs out-of-pocket.

(b) A second factor is the rising supply of physicians in relation to the population in combination with the constant level of services provided per physician. The number of physicians per 100,000 population has increased from 156 in 1970 to 211 in 1984, and will reach an estimated 243 by 1990.[1] The result has been an increase in the amount of medical care provided per person.[2]

(c) A third factor is the common comprehensive form of health insurance which insulates the patient and the physician from the true cost of services—so that there is little or no cost sensitivity influencing the choice among options in care. In 1983, 73 percent of personal health care expenditures were paid by third-party payers, ranging from 92 percent of hospital care to 72 percent of physicians' services and 44 percent of the remainder.[3]

(d) A fourth factor is medical technology. Innovations in medical technology have made it possible to treat patients with an array of high-cost therapies not previously available such as cobalt therapy, computerized tomography scanners, and coronary bybass surgery. These advances are costly for two reasons: (1) The capital acquisitions, such as new equipment and services, are costly and typically require specialized personnel to staff them; and (2) the increased availability of specialized and expensive services and equipment and the piecework method of payment often leads to excessive utilization. The Office of Technology Assessment [OTA] recently reported that "inappropriate use of medical technology is common and raises Medicare and health system costs without improving quality of care." The OTA study focused on coronary bypass procedures and use of intensive care units as examples of excessive use of costly technologies.[4]

The increased intensity of care provided per visit or per hospital stay to elderly Medicare enrollees is evident in the data shown in table 2. While the physician visit and hospital day indicators of health service use remained level over the decade of the 1970's and enrollment of the elderly increased only 26 percent, physicians' bills for services to them rose by 220 percent.[5]

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[1] U.S. Department of Health and Human Services. Health United States, 1982, p. 113.

[2] Freeland, Mark S. and Carol E. Schendler. "Health Spending in the 1980's: Integration of Clinical Practice Patterns With Management." Health Care Financing Review, vol. 5, spring 1984, p. 36.

[3] Health Care Financing Review, vol. 6, winter 1984.

[4] U.S. Congress, Office of Technology Assessment. "Medical Technology and the Cost of the Medicare Program." OTA-H227. July 1984.

TABLE 2.—HEALTH SERVICES UTILIZATION, SMI ENROLLMENT, AND PHYSICIAN BILLS—AGED

	1970	1980	Percent change
Physician visits (per aged)	6.3	6.4	+2
Hospital days (per 1,000 aged)	3,075	2,772	−11
SMI enrollment (millions)	19.6	24.7	+26
SMI bills (millions)	40	137	+244

Sources: Health services utilization—DHHS National Center for Health Statistics, Health Interview Data.
SMI enrollment and bills: DHHS, "Social Security Bulletin, Annual Statistical Supplement," 1982, pp. 205, 210.

Current discussions of Medicare reform are focused almost exclusively on questions of how to control expenditures: Should cost control measures be limited to reimbursement under the Federal programs, Medicare and Medicaid, or extended to all health care programs? What should be the relative roles of the Federal Government, State governments and the health care industries in any cost containment efforts? What impact will economic constraints have on the quality and availability of health care? What will be the impact of cost control efforts on the health care industry and its employees? Should cost containment be achieved directly through government's control of prices and reimbursement limits, or indirectly through competitive market forces?

2. APPROACHES TO COST CONTROL

(A) SCOPE OF COST CONTROL MEASURES

One issue in the cost containment debate is "What is the appropriate scope of cost control efforts?"

One option for cost containment is for the Federal Government to control costs directly through its own health care programs—Medicare, Medicaid, and the VA health system. These are the programs operated directly by the Federal Government or in partnership with the States. Proponents argue that only the cost of these programs are the legitimate concern of the Federal Government and that the private sector should be responsible for instituting its own cost control measures. Moreover, they argue, the private sector has its own incentives to control increases in health costs, and that Federal intervention would be more hindrance than help. Finally, its argued that an expansion of Federal responsibility would merely preserve inefficiently in the health care delivery system.

Another general approach to cost containment would be to control costs for all payers; since soaring health care costs are a national problem affecting all Americans, not just one affecting those persons served by government programs. Proponents of this view argue that a Medicare-only cost control program would probably not cause hospitals to reduce the rate of growth of overall costs, or to move to more cost-effective and efficient delivery of care. Rather, Medicare-only cost control would more likely result with Medicare becoming a program of second-class health care. As evidence, they cite the second-class health care and limited access of Medicaid recipients which has resulted from the low payment levels of the Medicaid Program.

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[5] U.S. Congress. Senate. Special Committee on Aging. "Medicare: Paying the Physician—History, Issues and Options," by Lynn Etheredge. Committee print, 98th Cong., 2d Sess. Washington, U.S. Govt. Print. Off., 1984, p. 11.

Many advocates of a systemwide approach are now turning to State governments for decentralized solutions, moreover, the Reagan administraiton has repeatedly opposed proposals for all-payer systems and have efficiently blocked further Federal action on this front. States have the legal authority to develop systemwide programs to control health care costs, and have the advantage over the Federal Government of being able to take account of local conditions and concerns in shaping their programs.

Several statewide programs are in existence. These "State all-payer systems," developed under waivers from Medicare's usual hospital payment method, control the hospital rates paid by all third-party payers including Medicare and Medicaid. In these systems, hospital rates or maximum annual revenues are set in advance, that is, prospectively, by a State agency. Hospitals are then at risk for any difference between the rates or revenue caps and their actual costs. Four States now have "all-payer systems"—Maryland, Massachusetts, New Jersey, and New York—and several other States are actively developing them.

(B) STRATEGIES OF COST CONTROL

Intertwined with the debate over the proper scope of the Federal Government's health cost containment measures are questions concerning the strategy by which costs should be contained. Should the Federal Government and/or State governments adopt the regulatory strategy and directly limit the charges, prices or total revenues of health care providers? Should the Government adopt the competitive strategy and try to stimulate the growth of price competition among providers? Or is it possible to combine both strategies—encouraging the growth of competition but using regulation to control costs in the meantime?

(1) Cost Control Through All-Payer Cost Regulation

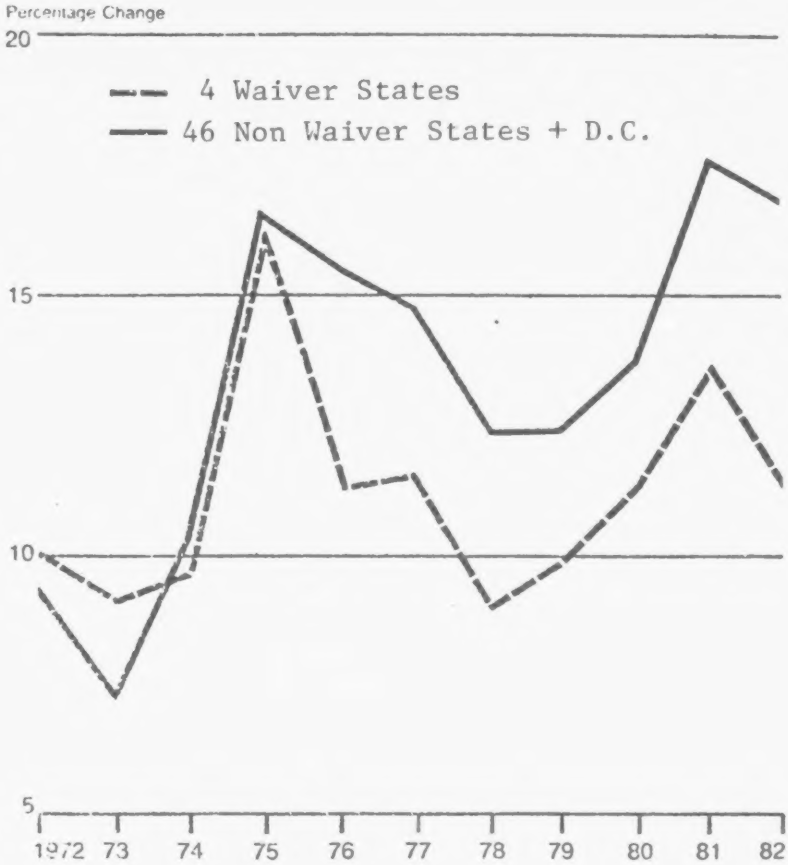
Advocates of a systemwide approach to controlling health cost increases support the regulatory strategy for the near term, because regulation is the only approach that will have a sufficiently rapid impact on cost increases. A combination of approaches is advocated by some of the large aging advocacy groups. State-level all-payer cost control, by regulation, has several advantages:

(1) It has a proven track record of success in limiting the rate of increase in hospital costs for all payers. This accomplishment is graphically illustrated in chart 2, which shows the smaller annual percentage change in expense per hospital admission in the four

all-payer or waivered States compared to nonwaivered States and the District of Columbia.[6]

CHART 2

ANNUAL PERCENTAGE CHANGE IN EXPENSE PER ADMISSION (ADJUSTED)



Johns Hopkins Center for Hospital Finance and Management

(2) It can be put into place and show positive results within a year or two of implementation, whereas the competitive approach seems likely to take many years to implement.

(3) It preserves a single class of care and equal access for all persons needing hospital care.

(4) It can be designed to fund hospital care for the indigent in an equitable manner for all third-party payers, and provide inner-city

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[6] Renn, Stephen. "Efficacy of Waivers: Payments to Four States Under the Medicare Program." (Unpublished study) Johns Hopkins Center for Hospital Finance and Management.

hospitals with payment for the large amount of care they provide to indigents. For inner-city hospitals, this payment can mean the difference between survival and closing down.

Critics of the regulatory approach argue that it will be ineffective in containing costs in the long run for three major reasons:

(1) Political pressures will cause State governments to allow inefficient hospitals to remain in operation.

(2) State regulation provides disincentives to efficiency. Reimbursement levels are linked to costs, so that a hospital that reduces costs experiences a proportional reduction in payment.

(3) The regulatory environment, with its inherent restrictions on profits, prevents the growth of competition between health care providers.

(2) The Competitive Strategy Plus Medicare-Only Cost Controls

The current administration has combined support for the competitive approach to cost containment with direct cost controls on Medicare and Medicaid only. President Reagan's first-term proposals included a variety of Medicare cost controls and increased cost-sharing, as well as a voucher program designed to increase competition among health providers. Congress did not approve the voucher proposal.

The Medicare vouncher plan in its original form would have allowed Medicare beneficiaries the option of receiving a voucher for a fixed dollar amount to apply toward the purchase of a qualified health insurance plan or health maintenance organization [HMO] membership. In another form, the voucher plan would be mandatory—providing vouchers to all Medicare beneficiaries.

Advocates cite several possible advantages to a voucher plan:

(1) It would lead to the organization of competitive medical plans which would vie for the Medicare market. To attract members, health care benefit plans would have to compete through price-and-benefit packages for their share of the market. Total health care spending might then be reduced if premium costs were reduced through greater cost-sharing on behalf of the insured, or if enrollment in less costly alternatives to the traditional fee-for-service system, such as HMO's increased.

(2) Increased beneficiary cost-sharing could reduce the demand for services by increasing the beneficiary's price sensitivity.

(3) The insuring plans would be pressed to hold down premiums by improving utilization controls and negotiating with service providers for reduced rates.

(4) Fee-for-service physicians and hospitals charging per-diem rates would also be affected, and might respond by organizing into HMO's or other units to compete for beneficiaries.

Critics of the competitive approach to health care cost-containment raise a number of concerns:

(1) The competitive approach may lead some health care organizations to skim the cream from the market, that is, to enroll only the healthier members of the population. The results would be adverse selection. Plans enrolling only healthier people would charge lower premiums and the remaining plans would be forced to enroll those with poorer health and charge higher premiums. Instead of

being broadly distributed, risk would vary substantially among plans and much of the risk-pooling advantage of insurance would be lost. In fact, concern that HMO's approved to enroll Medicare beneficiaries may skim has been a major factor behind the delay in the implementation of the Medicare HMO program. Also, if Medicare were to be completely converted to a voucher plan, the existence of insurance plans for the healthy and insurance plans for the sick could have serious consequences for the quality and access to care of elderly persons who are both sick and poor.

(2) Since the health care system has never been price-competitive, it is somewhat speculative to assume that reforms can create meaningful market force in this system. In addition, there is concern that if it were to become price-competitive, quality and accessibility of care would be sacrificed in the process.

(3) The transformation of health care provisions from a social service into a business could alter the incentives for providers and quite possibly alter the basic character of health care provision. Providers are assumed now to be motivated by the desire to help their patients get well. Business-oriented providers may have profit maximization as their primary motivation.

(4) The contention that consumer cost-consciousnes will reduce the use of costly or unnecessary care may not be true. Procompetition proposals assume that the insured now consume a great deal of unnecessary health care or unnecessarily expensive health care because it is "free at the time of delivery." Consumption, it is believed, can be reduced by offering consumers the opportunity to purchase cheaper insurance is with higher deductibles and copayments. These deductibles and copayments will make consumers price-sensitive and reduce their consumption of unnecessary or inordinately expensive forms of health care.

Critics argue that empirical evidence on insurance selection and health care consumption does not support this assumption. First, many employees in the Federal employee health benefits program, given the choice between high-cost comprehensive coverage and low cost, high-deductible coverage, have chosen the high-cost comprehensive coverage. Second, studies show that once an insured person contacts a physician, it is the physician and not the patient who determines the quantity and cost of the care provided. For this reason, higher deductibles and copayments have no effect on the amount and cost of health care delivered once the insured makes contact with a physician.[7]

For these reasons, attempts to increase the cost-sensitivity of consumers by raising beneficiary cost-sharing may result merely in shifting costs onto the consumer, without significantly reducing total health care expenditures.

Along with these criticisms, additional concerns have been raised specifically about the Medicare voucher plan.

(1) The overall value of vouchers may decline over time because voucher increases may not keep pace with health care cost increases. This would amount to reducing Medicare coverage and shifting more health costs onto the beneficiaries.

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[7] J. Newhouse, et al., "Some Interim Results From a Controlled Trial of Cost-Sharing in Health Insurance." New England Journal of Medicine. 305:1501, 1981.

(2) The voucher plan might not result in net savings because the private plans which would be providing insurance have higher administrative costs than the traditional Medicare Program, due to expenditures for advertising, enrollment activities, premium taxes, reserves, and profit margins.

(3) Particular groups that need a great deal of health care, such as end stage renal disease patients, would not be effectively served through a voucher plan. Private insurance plans would enroll them only at very high premiums or not at all. Therefore, these groups would have to retain Medicare or some comparable coverage. Questions remain on how the Medicare Program should be preserved to meet the needs of such particular enrollee groups.

(3) Combining Competition and Regulation

A third way to control health care costs is to take the middle road: to combine the regulatory and competitive approaches. This is a course recommended by some who back State all-payer regulatory programs for the near term. These State all-payer systems are viewed as the only available means of moderating cost increases quickly. At the same time, measures can and should be taken to encourage the growth of competing managed systems of care as typified by the health maintenance organization [HMO]. It is believed that, as more of these managed systems of care develop, costs will be controlled by the price competition among them. Then, the State's regulatory apparatus can be dismantled.

"Regulators" and "competitors" alike in the Congress agree that health care costs can only be controlled in a permanent way through transformation of the health care delivery system. This transformation would be from the current system in which physicians and hospitals earn more by providing more care to a system composed of managed care organizations which earn the most by providing health care in the most cost-effective ways.

The prototype of the managed care organization is the prepaid group-practice HMO. An HMO provides all the health care needed by one person or family for 1 year for a single prepaid annual fee. The HMO has conflicting incentives in this payment method. First, it is motivated to keep its members healthy to reduce their utilization of services. Second, however, it is motivated to minimize the amount and cost of treatment provided. In theory, these two incentives are in balance, since the HMO does not want to minimize care to the point that it jeopardizes the health of its members.

HMO's reduce their costs below the costs of traditional care delivery through a number of means. One is to use providers who are less expensive than physicians, e.g., nurse-practioners and physician-assistants, for some care provision. Another is to reduce expenditures for costly hospital care by performing surgery and diagnostic tests in ambulatory settings when this can be done without risk to the patient. Additional cost savings come from minimizing the length of hospital stays by keeping a close watch on the recovery of their hospitalized members. Through such measures as these, HMO's have demonstrated the capacity to provide the needed care at a cost substantially below that of care in the current delivery system where providing more health care means more revenues for providers.

One difficulty to date in relying on this solution to control health care costs has been the slow pace of HMO development. For many years, national and local physician organizations placed barriers in the way of HMO development. This opposition has gradually lessened over the years, and recently HMO's have been increasing in number, serving wider geographic areas and enrolling more members.

Legislation to give Medicare beneficiaries the option of HMO enrollment was enacted in TEFRA. The regulations to implement this law were issued in January 1985. This delay in implementation was due to problems in calculating the average adjusted per capita cost [AAPCC]—the Medicare HMO payment rate designed to approximate the Medicare costs for HMO enrollees. The publication of these regulations will now permit Medicare beneficiaries to join approved HMO's.

Both Medicare beneficiaries and the Medicare trust funds may experience significant benefits from this form of health care delivery. At the same time, Congress will need to remain alert to possible problems as more elderly persons enroll in HMO's. It is important not to lose sight of the fact that the incentive in prepaid care is to underproduce services. There is also the potential that some of these HMO's will fail and leave their members without coverage. The Medicare program has had limited experience with prepaid HMO care for the 65 and over population. Many Medicare HMO demonstrations are now under way, but it is not known whether the HMO approach to health care will be as successful in providing quality care in cost-effective ways for the 65 and over population as it has been for the under 65 population.

3. Prognosis for the Future of Cost Control

Until recently, there has been the remarkable absence of any private-sector force that opposes the unending expansion of the health care sector. The incentive of hospitals and physicians to multiply hospital capacity and high technology services, with the resulting explosion of costs, has been unchecked at community and State levels. The health industry has an almost unblemished record of success in winning the support of local State legislators for the expansion of services, equipment, and facilities.

This trend seems to be reversing. There is a growing awareness on the part of American employers, the major bill payers for the working population, that they are paying high prices for their employees' health insurance. Thus, there are now a growing number of employer coalitions designed to encourage local health care cost containment efforts. In the mid-1970's, there was only a handful of business coalitions on health. By the end of the decade there were about 50, and in 1984 an estimated 125.[8]

It is too soon after the formation of most of these coalitions to assess their effectiveness. However, the very existence of these coalitions holds the promise that, at local and State levels, there will be a countervailing force to oppose the seemingly infinite expansionary drive of the health care industry. One example of the potential impact of a business coalition on health care costs has been demonstrated in Rochester, NY. For 40 years, Rochester's business coalition has participated actively in decisionmaking on the size and shape of the community's health care system, acting to counterbalance the unrelenting provider pressures for increased hospital capacity and unlimited investment in new technologies. The result is a community which appears to have achieved economical care without sacrificing quality. The Rochester business coalition's long-term commitment to cost control may explain Medicare's relatively low cost per elderly person in this particular community. The 1981 Medicare cost per elder in Rochester, NY, was $1,067 (age/sex/wage adjusted), less than half that of Miami ($2,306), and 23 percent below the national average ($1,390), as shown in table 3.

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[8] Fox, Peter, Willis Goldbeck and Jacob Spies. "Health Care Cost Management: Private Sector Initiatives." Ann Arbor, Health Administration Press, 1984, ch. 5.

TABLE 3.—MEDICARE EXPENDITURES PER ELDER BY PLACE OF RESIDENCE, SELECTED SMSA'S, 1981

SMSA	Age/sex adjusted		Wage index [1]	Age/sex wage adjusted	
	Reimb/elder	Percent of NA		Reimb/elder	Percent of NA
Miami	2,304	166	0.999	$2,306	166
Los Angeles	2,270	163	1.156	1,964	141
Boston	1,782	128	1.022	1,744	125
Baltimore	1,663	120	.984	1,690	122
Chicago	1,868	134	1.149	1,625	117
Detroit	2,013	145	1.252	1,608	116
San Francisco	1,801	130	1.174	1,534	110
Des Moines	1,499	108	.996	1,505	108
Portland	1,592	115	1.060	1,502	108
New York	1,804	130	,1.208	1,493	107
Tampa-St. Petersburg	1,294	93	.871	1,486	107
Honolulu	1,415	102	.957	1,479	106
Phoenix	1,489	107	1.010	1,474	106
Flint	1,900	137	1.308	1,453	105
Pittsburgh	1,588	114	1.109	1,432	103
Cleveland	1,595	115	1.119	1,425	101
Minneapolis-St. Paul	1,481	107	1.057	1,401	100
New Orleans	1,432	103	1.027	1,394	100
National average (NA)	1,390	100	1.000	1,390	100
Albuquerque	1,309	94	.944	1,387	100
St. Louis	1,452	104	1.049	1,384	100
Newark	1,532	110	1.148	1,335	96
Denver-Boulder	1,401	101	1.118	1,253	90
Lansing-East Lansing	1,342	97	1.079	1,244	89
Rochester, MN	1,225	88	1.017	1,205	87
Houston	1,507	108	1.256	1,200	86
Dallas-Ft. Worth	1,205	87	1.080	1,116	80
Seattle-Everett	1,288	93	1.196	1,077	77
Davenport-Rock Island-Moline	1,200	86	1.120	1,071	77
Rochester, NY	1,192	86	1.117	1,067	77
Salt Lake City	1,055	76	0.988	1,067	77

[1] Based on ratio of area wage and salary earnings per job to U.S. average. Data source is the Bureau of Economic Analysis, Regional Economic Profile, 1976–81.

Note.—Medical expenditures refer to hospital insurance (HI) and supplementary medical insurance (SMI) reimbursements per beneficiary age 65 and over for covered services only. Date are from the Health Care Financing Administration, Bureau of Data Management and Strategy.

Source: Walter McClure and Dale Shaller, "Variations in Medicare Expenditures Per Elder.: Health Affairs. 3:120–129 (Summer 1984).

Federal and State governments are also becoming much more active about controlling health costs because government-funded health programs such as Medicaid and Medicare are consuming large proportions of government revenues. Additionally, governments with operating deficits are searching for ways to reduce their outlays, and health costs are a highly visible budget item. With government and the private sector both actively working to control health care costs, there may finally be some breakthroughs in the curbing of cost increases.

B. MEDICARE

Medicare was enacted in 1965 to insure older Americans for the cost of health care. During the last two decades, Medicare has provided millions of older Americans with access to quality hospital care and physician services at affordable costs. In 1984, Medicare insured over 28 million older Americans for health care.

As insurance for short-term acute illness, Medicare covers most of the costs of hospitalization and a large portion of the cost of physicians' services. Medicare does not cover the hospital costs of extended acute illnesses, however, and does not protect beneficiaries against potentially large copayments or charges above the Medicare payment rate for physician services. These shortcomings in Medicare's coverage of the costs of acute illness lead two-thirds of older Americans to purchase private insurance to supplement their Medicare insurance.

At a 1984 estimated cost of $63 billion, Medicare is the second most costly Federal domestic program, exceeded only by the Social Security Program. The costliness of the Medicare health insurance program is due to the high cost of American health care in general.

The increasing costs of the Medicare Program have been of longstanding concern to the Congress. In the last few years, this concern has been heightened by the large Federal deficits which first occurred in 1982 and are projected to continue throughout the decade. Because of the deficits, the Medicare Program has been targeted repeatedly for Federal spending cuts. Medicare is an attractive target for spending reductions because it is such a rapidly increasing percentage of the total Federal budget. In 1980, Medicare expenditures were 6 percent of the total Federal budget, rising to 7 percent (estimated) in 1983, and projected to be 9 percent by 1988.[9]

Since 1981, there has been a major change in Medicare's reimbursement of hospitals and incremental changes in beneficiary coverage and cost-sharing and physician reimbursement—all directed at reducing Federal expenditures. Changes around the margin of the program will continue into the foreseeable future. Whether there will be any major changes in the program within the next few years is uncertain.

Current revenues for the Medicare hospital insurance trust fund are less than expenditures, so that the fund's balance is shrinking. Without changes in current law, it would reach zero sometime during the decade of the 1990's. In working out the means to prevent the upcoming insolvency of the trust fund, Congress may make broad systemwide changes in the Medicare Program. There is, however, no consensus at this time about how reform would be achieved: some, for example advocate a direct means to restore the solvency of the trust fund—with proposals that include new funding sources—such as additional premiums, an income tax surcharge to be paid by Medicare beneficiaries, dedicated additional taxes on alcohol and tobacco, and funds from general tax revenues—through altered payment incentives to make providers more efficient; others propose to transform the basic mode of health care delivery, to a delivery system dominated by organizations that manage health care provision; still others suggest that Medicare costs can be contained by cutting back coverage or by means testing benefits or eligibility.

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[9] U.S. Library of Congress. Congressional Research Service. "1984 Budget Perspectives: Federal Spending for the Human Resource Programs. Report No. 82-60 EPW," by Earl Canfield, Richard Rimkunas and Gene Falk, Washington, 1983, p, 77.

In 1984, the first major Medicare reform bills aimed at remedying the insolvency of the hospital insurance trust fund and other serious problems in the Medicare Program were introduced into the Congress, but no action was taken on them. The administration and the Congress limited their actions to marginal cost-saving alterations in Medicare which were proposed and acted upon in the overall context of deficit reduction.

1. MEDICARE PROGRAM DESCRIPTION

Medicare (authorized under title XVIII of the Social Security Act) is a nationwide program that provides health insurance protection to most individuals age 65 and over, to persons under 65 who have been entitled for a period of 24 months to Social Security or railroad retirement benefits because they are disabled, and to certain workers and their dependents who need kidney transplantation or dialysis. Medicare is a Federal program with uniform eligibility and benefit structure throughout the United States. Protection is available to insured persons without regard to their income or assets. Medicare is composed of two parts—the Hospital Insurance Program (part A), and the Supplementary Medical Insurance Program (part B).

Part A is financed principally through a special hospital insurance payroll tax levied on employees, employers, and the self-employed. During calendar year 1984, each worker (including the self-employed) and employer paid a tax of 1.3 percent on the first $37,800 of covered employment earnings. During each benefit period (defined as beginning when an insured person enters a hospital and ending when he has not been in a hospital or skilled nursing facility for 60 days), part A pays for:

(1) Ninety days of inpatient hospital care subject to a deductible ($400 in calendar year 1985); a daily copayment ($100 in 1985) is required for the 61st through 90th day. An additional lifetime reserve of 60 days, subject to a daily copayment ($200 in 1985) may be drawn upon when an individual exceeds 90 days in a benefit period. Both the deductible and copayment amounts are annually adjusted.

(2) One hundred days of post-hospital skilled nursing facility [SNF] care, subject to a daily copayment ($50 in 1985) after the first 29 days.

(3) Home health care provided on a part-time or intermittent basis. There is no limit on the number of visits or no copayment is required.

(4) Hospice coverage of terminally ill beneficiaries with a life expectancy of 6 months or less.

Part B of Medicare is a voluntary program financed jointly through monthly premium charges on enrollees, $15.50 in 1985, and Federal general revenues. Premiums cover 25 percent of program costs; 75 percent are funded from general revenues. Part B—with certain exceptions—pays 80 percent of reasonable charges for the following covered services after the insured meets a $75 deductible: physician and other services, diagnostic tests, medical devices, outpatient hospital services, and laboratory services.

Hospital reimbursement under the Medicare Program is now in transition from the original retrospective reimbursement-of-costs method to the new prospective payment method. Under the prospective payment method, hospitals are paid a set price for each type of case, as classified by diagnosis related group [DRG]. The phasein of prospective payment by DRG rates began in October 1983, and will be completed by October 1988.

Physician reimbursement.—Medicare pays physicians the "reasonable charge rate" for each service, less beneficiary deductible and copayment. The reasonable charge for a service is the lowest of three dollar amounts: (1) the physician's actual bill for the services, (2) the amount which the physician usually charges for this service, or (3) the prevailing charge made for this service by all physicians in this locality. This complicated reimbursement method is considered to have a number of undesirable consequences—discussed below—and is likely to be altered within the next few years.

The Medicare Program has provided substantial benefits to older Americans. In 1963, 2 years before the enactment of Medicare, half of the aged had no private health insurance. Today, over 95 percent of Americans age 65 and over are insured by Medicare. In 1985, there will be an estimated total enrollment of aged beneficiaries of 28 million, with more than 27 million enrollees in each the hospital insurance program and the supplementary medical insurance program.[10]

Medicare has succeeded in its goal of providing the elderly with access to mainstream health care. Ninety-three percent of the elderly have a regular source of medical care, and 83 percent see a physician at least once a year. Also, Medicare has been successful in eradicating the differences evident prior to 1965 between the poor and the nonpoor elderly in the use of hospitals and physician services. Improved access to health care has helped to improve the health status of the elderly since the inception of the program.

2. ISSUES

The factors that drive the cost of Medicare are the same factors that drive the cost of the entire national health care system. This is seen in the parallel increases in national health expenditures and Medicare expenditures since 1967—the first full year of the Medicare Program. Total national health expenditures rose from $51 billion in 1967 to $322 billion in 1982, an average annual rate of increase of 12 percent. Over the same period, Medicare outlays also increased steadily, from $4.7 billion in 1967 to $52 billion in 1982—although at the somewhat more rapid average annual rate of 17 percent.[11]

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[10] Aiken, Linda H. and Karl D. Bays. "The Medicare Debate—Round One." New England Journal of Medicine, vol. 311, Nov. 1, 1984, p. 1196.

(A) SOLVENCY OF THE HOSPITAL INSURANCE TRUST FUND (PART A)

A major problem facing Medicare is the projected revenue shortfall in the hospital insurance trust fund (part A). The exact year of insolvency cannot be predicted with accuracy, but insolvency is inevitable since trust fund expenditures now exceed revenues and will continue to do so until some action is taken to remedy this imbalance. The most recent estimates by the Congressional Budget Office project that the trust fund balance will reach zero in 1994 (see table 4).

TABLE 4.—PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND OUTLAYS, INCOME, AND BALANCES

[By fiscal year, in billions of dollars]

Years	Total outlays	Income	Year-end balance
1985	48	52	20
1986	53	61	29
1987	59	73	43
1988	66	72	49
1989	74	75	51
1990	82	79	48
1991	92	85	41
1992	103	91	28
1993	116	97	9
1994	130	102	−18
1995	146	107	−56

Source: Congressional Budget Office, August 1984 estimates.

During 1984, the year's most important conference on Medicare reform was held in February by the Subcommittee on Health, the Committee on Ways and Means, U.S. House of Representatives. Experts on Medicare were invited to present and discuss possible reforms of Medicare.[12]

Among the issues discussed were:

(1) Proposals to restructure benefits by varying beneficiary copayments according to the costliness of providers—the more costly the provider used, the higher the copayment percentage; catastrophic coverage of health care costs with maximum out-of-pocket costs varying according to beneficiary income; and a mandatory voucher system.

(2) Proposals to control the rate of increase in Medicare's payments to physicians by establishing regional limits on the rate of

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[11] Freeland, Mark S. and Carol E. Schendler. "Health Spending in the 1980's." Health Care Financing Review, vol. 5, spring 1984, pp. 9-10.

[12] U.S. Congress. House. Committee on Ways and Means. Subcommittee on Health. Proceedings of the Conference on the Future of Medicare. WCMP:98-23. Committee Print, 98th Cong., 2d Sess. Washington, U.S. Govt Print. Off., 1984.

increase in total payments for physician services. To limit increases in Medicare costs from new medical technologies and procedures, responsibility could be assigned to a technology assessment office to evaluate the effectiveness of new technologies and procedures to be used by HCFA for reimbursement.

(3) Proposals for additional revenue sources included a tax on the widely purchased, private Medicare-supplemental insurance which pays Medicare's beneficiary cost-sharing requirements by covering deductible and copayments, a premium increase, and new taxes on alcohol and cigarettes to be dedicated to the Medicare trust fund. Another proposed reform was the merging of parts A and B into a single Medicare trust fund, in order to coordinate all reimbursement incentives in the program and to facilitate development of managed systems of care for Medicare beneficiaries.

(4) Proposals to replace the present SMI premium with a combined premium for parts A and B which would be collected through the income tax system and varied according to beneficiary ability to pay.

(B) PAYING PHYSICIANS (MEDICARE PART B)

The Supplemental Medical Insurance Program [SMI] now represents about one-third of all Medicare expenditures. It has grown in recent years at a faster rate than hospital insurance expenditures. In 1984, SMI expenditures rose at an annual rate of 11 percent—almost three times as fast as the overall rate of inflation. Seventy-five percent of SMI expenditures are for physician services.

The SMI trust fund cannot become insolvent since the portion of the program not covered by enrollee premiums is funded from general tax revenues. (In 1985, one-quarter of program costs will be paid by premiums and the remaining 75 percent will be paid from the general revenue fund.) However, the size of the fund's outlays and their rapid rate of increase have generated considerable interest in the Congress and the administration in bringing these outlays under control.

There is currently no consensus on the payment method which will replace Medicare's current customary, prevailing, and reasonable charge [CPR] method of paying physicians (described previously in Medicare Program Description: Physician Reimbursement). However, there is a widely shared view that the CPR method is unsatisfactory for many reasons: [13]

(a) It leaves Medicare patients exposed to considerable out-of-pocket costs. Physicians can decide, for each bill, whether to take assignment, that is, to accept as full payment what Medicare deems a reasonable fee. This means that patients often do not know in advance of being treated whether they will have to pay their physician an additional amount above and beyond the required 20 percent copayment of the Medicare reasonable charge.

(b) The reimbursement structure contains perverse incentives to physicians, which encourage them:

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[13] Jencks, S. and A. Dobson. "Evaluating Options for Reforming Medicare's Physician Payment Process: Physician DRG's and Alternatives (staff paper)." Office of Research, Health Care Financing Administration, August 1984.

—To perform surgery and technologically based diagnostic care rather than give consultative care.

—To treat patients in a hospital rather than in ambulatory settings.

—To neglect the provision of preventive and early care.

—To practice an extravagant style of medicine, rather than a conservative style, doing more rather than less to their patients.

—To choose specialization over family practice, and to choose among specialities on the basis of their differential earning potential.

(c) It places no limits on the quantity of services which physicians can elect to deliver, so that congressional attempts to limit fund outlays through limiting fee increases can be circumvented by simply increasing the number of services provided.

(d) The reasonable charge methodology is so complicated that it is understood by few doctors and even fewer patients. Many doctors do not know their Medicare customary rates or the regional prevailing rate for the services they commonly provide. This may be a factor in the unwillingness of many physicians to accept assignment on their Medicare bills. Ignorance of the Medicare payment rates may make physicians reluctant to commit themselves to accepting these rates as payment in full.

The Congress has requested reports on the two options for reform of Medicare physician payment: (1) a fee schedule, and (2) physician-DRG's. Both are reforms that would preserve the present dominant mode of physician practice, that is, individual or group private practice on a fee basis. The national physician organizations are promoting the fee schedule payment method.

Fee schedule.—The first option is to change from CPR to a fee schedule. This would mean that all physicians in a region would be paid the same fee for a given service, rather than the CPR arrangement in which different physicians receive different fees for a given service. If this option is selected, an effort will be made to set the fees for various services so that there is a reasoned, relative relationship between the fees, that is, to develop a rational relative value scale [RVS]. For example, fees might be set so that a physician's time would be compensated at the same hourly rate whether care is delivered in the hospital or in the doctor's office. Currently, physicians' hospital time is reimbursed, on average, at about five times more per hour than physicians' office time.[14] A number of insurers already pay physicians according to a fee schedule. Thus it is a payment method that is familiar to physicians.

The most serious shortcoming in the fee schedule approach is that it does not provide any check on the ever-increasing intensity of care, that is, the number and complexity of services provided per beneficiary. So long as the intensity of care for Medicare beneficiaries continues to increase, it will not be possible to bring part B costs under control.

The Office of Technology Assessment has been directed to report to the Congress by December 31, 1985, on: (1) the advisability, feasibility and methods for developing fee schedules and relative value scales; (2) the influence of alternative payment methods and payment levels on the utilization of services; and (3) methods to increase incentives to physician to accept assignment.

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[14] Hsiao, W.C. and W.B. Stabon. "Toward Developing a Relative Value Scale for Medical and Surgical Services." Health Care Financing Review. Fall 1979, vol. 1, No. 2, pp. 23–38.

Physician-DRG's.—The second option is to change the unit of care for which a fee is paid—from the unit of each individual service to a unit consisting of all the physician services delivered during a single hospitalization. The payment amount would vary according to the patient's diagnosis [DRG]. This payment method is termed M.D.-DRG's or physician-DRG's. The lump sum payment might go either to the principal physician in the case or to the hospital; the recipient would then be responsible for paying all physicians who provided services to the patient during this hospital admission.

The greatest strength of the M.D.-DRG is that it contains a powerful incentive to physicians to check the increasing intensity in hospital care, where high intensity results in both large physician bills and high secondary costs to Medicare. On the other hand, it might turn out to act as a powerful disincentive for physicians to provide adequate care. However, all such statements about the impact of M.D.-DRG's are speculative since M.D.-DRG's are at present only a theoretical concept; they have never actually been used for physicians.

That there has been a virtual absence of any experience with the M.D.-DRG payment method, however, may rule out the possibility of early enactment. Certainly, there is reluctance among policymakers to adopt a major reform of Medicare without first having some evidence of its impact. On the other hand, there is strong pressure on Congress to act soon to limit Medicare part B outlays, and it could be argued that the hospital DRG's were only in the early stages of its first test when enacted as Medicare's national payment method.

The technical capability necessary for calculation of M.D.-DRG payment rates is now being developed by a HCFA contractor. Congress has directed DHHS to report by July 1, 1985, on the feasibility and advisability of paying physicians on a DRG basis.

(C) PROPOSALS FOR MEDICARE REFORM

In 1984, two comprehensive Medicare reform bills that address Medicare's cost problems were introduced in the Congress: The Medicare Incentives Reform Act (S. 2752, Senator Heinz) and the Medicare Solvency and Health Care Financing Reform Act (S. 2424/H.R. 4870, Senator Kennedy and Representative Gephardt). These bills are representative of reform proposals that could solve Medicare's fiscal problems while maintaining the almost universal program entitlement and preserving or improving its coverage of acute care.

The key features of these two bills are described below:

—*State cost control:* Both bills provide incentives to States to develop all-payer hospital cost control systems which would be regulatory. However, the regulations must leave room for the free growth of competitive HMO's outside of the regulatory system. Under the Heinz bill, all-payer cost control is a State option. It is mandatory under the Kennedy-Gephardt bill—States would have a fixed time period in which to establish their own all-payer systems, and States which failed to do this would have a Federal all-payer system imposed on them.

—*Physician costs:* Both bills tackle the problem of how to limit the rate of increase in Medicare expenditures for physician services. The Heinz bill would implement a relative value scale/fee schedule with regional caps on the annual rate of increase in total physician service expenditures. The Kennedy-Gephardt bill contains the M.D.-DRG approach, with cost increases held to the increase in the hospital market basket. Both bills would immediately require physicians to accept the Medicare reasonable rate for inpatient services as payment in full—i.e., accept assignment. The Heinz bill would require assignment of all physican bills at the time the relative value/fee schedule is implemented.

—*Additional revenues* for the HI trust fund. The Heinz bill would double the cigarette tax and dedicate these revenues to the HI trust fund. The Kennedy-Gephardt bill transfers funds from general revenues to the HI trust fund.

—*Increased coverage* of acute care costs is provided by the Heinz bill. For an additional premium, Medicare would cover the full cost of physician services after the initial deductible had been met and unlimited days in the hospital, with no copayments.

These two major bills contain an array of options for addressing Medicare's problems and shortcomings. As the policy search continues, the Heinz and Kennedy-Gephardt reform proposals will be a useful starting point for structuring further debate.

(D) HOSPITAL PROSPECTIVE PAYMENT SYSTEM (PPS)

Although the prospective payment method (which utilizes DRG's) has been in effect for a year it is still too early to have any clear idea of its full consequences. While implementation began in October 1983, hospital entry into the phase-in is staggered, so that some hospitals did not begin the first year of their 3-year phase-in until as recently as September 1984. The first reports on the effects of DRG's should be received in 1985, and are expected to provide Congress measures of whether DRG's are improving hospital efficiency and whether they are having adverse effects on quality and accessibility to care.

One effect of the DRG legislation is already clear; hospital administrators appear to have become more knowledgeable about hospital cost factors. For the first time, data collection and accounting systems are being installed in hospitals to provide the administrators with the capability to delineate the cost components in treating specific types of cases and to provide information on the relationship between costs and revenues. The postitive side of these new capabilities is that they provide hospitals with information that can help them be more efficient. The negative side is that with the ability to forecast the types of cases that will be revenue "winners" and "losers," hospitals may begin to exclude all but the most profitable cases.

As of December 1984, there is almost no concrete information on the impact of DRG's on hospital utilization. It is known that the average length of hospital stay by Medicare beneficiaries has continued to decline, but that trend began before the enactment of DRG's. Also, the Medicare per capita hospital admission rate has leveled off. But it is not known to what extent these changes in utilization patterns are caused by the Medicare prospective payment system.

(1) National or Regional DRG Rates?

One issue that may surface in the 99th Congress is whether to go ahead with the scheduled change from regional DRG rates to uniform national DRG rates. The substantial regional differences in hospital costs were recognized in setting the initial DRG rates. But, at the end of the implementation period, there are to be no regional differences (except adjustments for regional wage variations) in the DRG rates. These national rates will be the national average cost per DRG. Hospitals with costs above the average will receive less payment, and hospitals with costs below the average will receive higher payment.

Hospitals in high-cost regions that will lose revenues under a national rate are already lobbying for a slowdown or halt in the transition to national rates.

(2) Hospital Capital Costs

In 1985, the Congress could take up reform of Medicare's method of reimbursing hospitals for capital costs. Under current law, hospitals are reimbursed on the retrospective cost basis for their expenditures for equipment and facilities, including interest, depreciation costs, and return on equity. The pass-through of capital costs has encouraged hospitals to make capital investments, whether or not they were essential for the provision of a good standard of care or whether there was a community need for the equipment or facilities.

When hospital prospective reimbursement was enacted in 1983, the reform of capital reimbursement was put aside for later resolution, pending a report to Congress from the Department of Health and Human Services on policy options and recommendations. The report is due to the Congress by November 1, 1985.

(3) Paying for Indigent Care and Medical Education

Traditionally, the costs of medical education and hospital care for the uninsured (indigent care) have been included in hospital rates. These costs have been major causes of the high rates of teaching hospitals which are often located in inner cities and serve large numbers of the poor and near poor. Medical education costs are already spread equitably across all third-party payers.

Following a hearing held in October 1984 by the Senate Finance Committee, Senator Durenburger proposed to strip indirect subsidies out of Medicare's DRG payments to hospitals, so that the DRG rates will cover only direct costs of patient care. This would mean removing any costs of indigent care and medical education from the DRG rates, with a resulting reduction in Medicare expenditures. Senator Durenburger is expected to reintroduce a proposal to establish a separate block grant to States for medical education during the 99th Congress.

If indigent care and medical education costs are removed from the hospital payments made by private third-party payers it would be necessary to make alternative funding arrangements for these purposes.

Indigent care could be financed through continued payments by third-party payers in such a way that would improve the current inequitable distribution: States could add a charge or a tax to all hospital payments made by third-party payers, and use these revenues to reimburse hospitals for indigent care.

(E) MEDICARE WAIVERS FOR STATE ALL-PAYOR SYSTEMS

The statutory authority for State Medicare waivers permitting States to control hospital costs by using a uniform payment system for all payers was established in Public Law 98-21, section 601 (Social Security Amendments of 1983). The issuance and renewal of Medicare waivers for State all-payer hospital cost control programs is likely to be an issue in 1985. A number of States are expected to apply for waivers and there is some indication that the administration no longer supports the waiver option.

Of the four States—Maryland, Massachusetts, New Jersey, and New York—which now have Medicare waivers for their all-payer programs, all but Massachusetts will be seeking waiver renewals during 1985. Other States will be seeking initial waivers from the Health Care Financing Administration.

The administration's lack of support for Medicare all-payer waivers is evident in its delay in issuing the regulations for implementation of the statute. One and one-half years after enactment, the Department of Health and Human Services has still not published the draft version of regulations for implementation of this legislation. The delay is attributed to two factors: One is opposition within the administration to waivers for any health care programs which may cost additional Federal dollars; some believe that State all-payer systems may fall in this category. A second is the more philosophical opposition to State all-payer cost control programs on the grounds that such regulatory programs prevent the development of competition within the health care sector; competitive forces are viewed by some as the only long-range solution to excessive health care costs.

It is possible that, as individual States encounter opposition from the Department of Health and Human Services to their waiver requests, the States will turn to the Congress, as they have in the past, for support.

3. LEGISLATIVE ACTIVITY

A number of changes were made in the Medicare Program by the Deficit Reduction Act of 1984 [Public Law 98-369]. Beneficiaries will be directly affected by the increase in the part B premium, the increase in cost sharing for durable medical equipment, and modifications in Medicare coverage of the working aged. The Medicare customary and prevailing rates for physicians were frozen for a 15-month period. For hospitals, the maximum rate of increase in per case payments in 1985 was reduced from hospital market basket plus 1 percent to hospital market basket plus one-quarter of 1 percent. Prospective payment for clinical laboratories was enacted, to replace cost-based reimbursement.

The Medicare provisions of the 1984 Deficit Reduction Act will result in an estimated savings of $2.9 billion in fiscal year 1985 and $11.3 billion over the 4-year period from fiscal year 1984 to 1987. The single provision with the largest program savings is the physician fee freeze.

(A) PROVISIONS AFFECTING BENEFICIARIES

(1) Part B Premium as a Constant Percentage of Program Costs

When the Supplementary Medical Insurance Program began in 1965, beneficiary premiums were to finance 50 percent of the costs of the program and the remaining 50 percent were to be financed from general revenues. This was the case from 1966 to 1972. Beginning in 1973, the annual percentage increase in the premium was not allowed to exceed the percentage increase in Social Security cash payments. As a result of this limitation, by 1982 the portion of part B costs paid through beneficiary premiums had declined to about 24 percent of program costs. TEFRA, 1982, raised the part B premium for two 1-year periods, beginning on July 1, 1983, to the amounts necessary to cover 25 percent of program costs.

In both 1983 and 1984, the President's budget included a proposal to increase the portion of part B costs paid by beneficiary premiums from 25 percent in 1984 to 35 percent in 1988. These proposals did not receive congressional approval. Rather, the July 1, 1983, premium increase was delayed to January 1, 1984, to coincide with the delayed cost-of-living increase in Social Security cash benefit payments [Public Law 98-21]. Also, the temporary increase in premium levels to the amount necessary to cover 25 percent of program costs has been extended through 1987 [Public Law 98-369]. The monthly premium is $15.50 per month in 1985, and estimated at $16.40 in 1986, and $18 in 1987. Given the continuing steep rise in the part B program costs, further proposals to increase the percent of program costs financed by premiums seem likely.

(2) Copayment for Durable Medical Equipment

Under prior law, Medicare paid 100 percent of the reasonable charges for medical devices provided by home health care agencies. With the passage of the Deficit Reduction Act of 1984, the beneficiary copayment of 20 percent of reasonable charges for purchase of durable medical equipment not included as part of a covered inpatient service now applies to the purchase of all durable medical equipment, including that provided by a home health agency.

(3) Modified Medicare Coverage of the Working Aged and Their Spouses

The Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA] included a provision requiring employers to offer their employees aged 65 to 69 the same health benefits plan offered to their younger workers. Medicare is the secondary payer with respect to these older workers and their spouses aged 65 to 69. Aged employees who chose to enroll in their employer-offered benefit plan might wish to delay enrollment in part B because the coverage is duplicative. However, persons who delayed enrollment were subject to a penalty.

The 1984 Deficit Reduction Act waives the part B enrollment penalty for these workers and their spouses who elect private insurance under the TEFRA provisions. The act also requires employers to offer group coverage to an employee who has not reached age 65 in cases where the employee has a spouse 65 to 69 years of age under the same circumstances as coverage is offered to employees with a spouse under age 65. The effect of this provision is to shift some health care costs from Medicare to these employees and/or their employers. Some Members of Congress are concerned that this shift of health care costs of the working elderly and their spouses from Medicare to the employer makes the employment and retention of older workers less attractive to employers. If this Federal policy leads to reduced employment of older persons, it may prove to be counterproductive since immediate cost savings could be offset by lost tax revenues from unemployed older persons.

(4) One-Month Delay in Eligibility (Not Adopted)

Congress did not enact the administration's proposal in the fiscal year 1985 budget that eligibility for Medicare be delayed for 1 month—from entitlement starting the month during which an individual reaches 65—current law—to entitlement starting the following month. This provision would have hit hardest that portion of the elderly who are without adequate health insurance as they approach age 65. This includes an unknown number of persons who delay seeking treatment for illnesses until they are covered by Medicare insurance. For those with adequate insurance, the proposal would shift the cost of insurance in this month from Medicare to the individual and/or his employer.

(5) Expanded Coverage of Hepatitis B Vaccine

Under prior law, Medicare's coverage for immunizations and vaccines was limited to pneumococcal vaccine. Public Law 98-369 authorizes coverage for hepatitis B vaccine for end-stage renal disease and other high risk Medicare beneficiaries.

(B) PROPOSALS AFFECTING PROVIDERS

(1) Physician Fee Freeze

By 1983, there was widespread agreement in the Congress and the administration that the time had come for physicians to make a contribution to the limiting of the Medicare expenditures. Of the more than $16 billion in Medicare cuts made from 1981-83, those aimed at doctors came to only about $2 billion compared with just under $5 billion on the beneficiary side and about $9 billion on the hospital side. Despite the general concern among policymakers about measuring part B payments to physicians, few creative solutions were proposed. Instead a stopgap measure was enacted: a temporary freeze on Medicare's physician customary and prevailing charge levels.

Under current law, payments for physician services under Medicare are made on the basis of *reasonable charges.* The reasonable charge for a service cannot exceed the lowest of:

—The *actual charge* for the service.

—The physician's *customary charge* for the service; and

—The *prevailing charge* for similar services in the locality—set at a level no higher than is necessary to cover the 75th percentile of customary charges.

Customary and prevailing charges have been updated annually, subject to an economic index limit on the maximum increase. The freeze proposal was to cancel the 1984 updating of the screens.

Several aging advocacy groups were concerned that this proposal might not have the intended effect of temporarily freezing physicians' Medicare incomes. Rather, physicians might transfer the intended impact of the fee freeze from their own pockets back to Medicare or to beneficiaries' pockets. This could happen in two ways:

(1) Physicians could increase the number of services they provide to their Medicare patients and thereby continue to increase the total dollar amount of physician billings to Medicare. The Senate Special Committee on Aging, in its hearing, "Medicare: Physician Payment Options," heard that this had been the physician reaction to fee level restrictions in two earlier periods. Such a reaction would mean that the fee freeze would not produce the intended reduction in Medicare part B outlays.[15]

(2) Physicians could increase the dollar amount in the part of the bill that is paid by patients. If this should occur, again the physicians would end up even and the patients would be the ones who paid for the savings in part B outlays. Various suggestions were forthcoming on ways to prevent or minimize this form of shifting costs onto the beneficiary. The most powerful proposal came out of the Health Subcommittee of the House Ways and Means Committee: A provision that linked a freeze on physician inpatient fees with a requirement that physicians accept assignment for all Medicare inpatient services. This provision was opposed by physician groups and did not pass the House.

The House of Representatives was unwilling to pass a physician fee freeze provision that was not linked to substantial protection of beneficiaries against cost-shifting. For this reason, the House spending reduction legislation, H.R. 5394, did not include a physician fee freeze.

H.R. 5394 did include a provision intended to help beneficiaries be informed consumers of health care: DHHS was instructed to provide beneficiaries with information on physicians' percentage of assigned claims, and names of physicians who had voluntarily agreed to accept assignment in all cases, termed "participating physicians." The Senate's 1984 deficit reduction legislation contained a similar provision and, additionally, extended the fee freeze through a second year for nonparticipating physicians.

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[15] Rice, Thomas. U.S. Congress. Senate. Special Committee on Aging. Medicare: Physician Payment Options. Hearings, 98th Cong., sess., Washington, U.S. Govt. Print. Off., 1984.

The American Medical Association opposed the mandatory freeze on Medicare payment rates. As an alternative, the AMA asked all physicians to voluntarily freeze their fees across-the-board. The AMA estimated that most of its members would comply with the voluntary freeze; the senior citizen groups were dubious.

The Congress voted a mandatory fee freeze, in combination with civil penalties for those physicians who fail to comply with the freeze. Public Law 98-369 freezes the Medicare customary and prevailing charges for 15 months for all physicians, beginning July 1, 1984. Therefore, the fee screen increases otherwise slated for July 1, 1984, did not occur. Subsequent fee screen updates will occur on October 1 of future years, beginning in 1985.

The act also establishes the concept of a "participating physician." A participating physician is one who voluntarily enters into an agreement with the Secretary to accept for a future 12-month period (with the first such period beginning October 1, 1984) assignment for all services provided to all Medicare patients. Participating physicians are subject to the 15-month freeze of customary and prevailing charges. However, they can increase their billed charges during this period and these increased charges will be reflected in their future customary fee screen updates. The act includes additional incentives to physicians to become participating physicians, including the publication of directories identifying participating physicians.

Nonparticipating physicians—that is, those who have not signed a voluntary participation agreement—can continue to accept assignment on a case-by-case basis. However, to protect the beneficiaries from physician cost-shifting in the form of fee increases, the nonparticipating physicians are not allowed to increase their billed charges during the 15-month freeze. For example, if a physician currently charges $22 for a service and Medicare's reasonable charge is $20, he can bill the beneficiary for the 20 percent coinsurance ($4) plus (if he does not accept assignment) the $2 in excess of the reasonable charge. During the freeze period, the nonparticipating physician's fee would be frozen at $22—he cannot raise his charges to beneficiaries to circumvent the freeze. Nonparticipating physicians who do not comply with the fee freeze are subject to civil monetary penalites of up to $2,000 and/or exclusion from the program for up to 5 years.

AMA law suit.—The American Medical Association has sued HHS, claiming that the fee freeze is unconstitutional. The AMA asserts that the fee freeze violates the equal protection clause because "Medicare beneficiaries will be precluded from paying what physicians charge to other patients and therefore may come to be regarded as second-class citizens," and that it violates the due process clause by requiring physicians to decide whether or not to participate while HCFA and the Medicare carriers cannot provide physicians with their current charge profiles on which to base their decisions. (*American Medical Association et al.* v. *Heckler* (S.D. Ind. filed September 26, 1984.)

(2) Limitations on Growth of DRG Rates

The phased-in implementation of Medicare's new prospective payment system for hospitals began in October 1983, and will be completed by october 1988. The general sentiment of the Congress in 1984 was that time should be allowed for implementation and evaluation of this radically new reimbursement method before any major changes are made in it. As a result, the Deficit Reduction Act made only minor modifications in the original PPS legislation. The 1985 maximum rate of increase in Medicare payments per case is reduced from "hospital market basket plus 1 percent" to "hosptial market basket plus one-quarter of 1 percent." Several provisions are directed at correction of problems in the urban/rural classification and payment differentials of hospitals. Study and correction of the adjustments in the labor component of DRG rates are ordered. Finally, payment for certified nurse anesthetist [CRNA] services is removed from the DRG payment; in the future CRNA services are to be paid on a reasonable cost basis.

(3) Fee Schedules for Laboratory Services

Under prior law, diagnostic laboratory services for ambulatory patients were reimbursed by Medicare on a reasonable charge or reasonable cost basis. Assignment was required only for the services provided by hospital labs to hospital outpatients.

Public Law 98–369 establishes fee schedules for all laboratory services to ambulatory patients. The reimbursement of hospital-based laboratory services provided to hospital outpatients according to a fee schedule has a 3-year time limit, unless the Congress acts to include these services in a national fee schedule.

All independent and hospital laboratories are required to accept assignment. Physicians can choose to accept or not accept assignment on a case-by-case basis. When assignment is accepted, reimbursement is at 100 percent of the fee schedule amount, and the coinsurance and deductible do not apply.

4. REGULATORY CHANGES

In the Medicare prospective payment system for hospitals, HHS must annually set rates in advance for the 468 categories of illness, called diagnosis related groups [DRG's], into which hosptializations are classified. Each DRG is assigned a weight which reflects the cost of hosptial treatment for this diagnosis as compared to other diagnoses. A routine hospitalization for pneumonia, for instance, has a lower weight than the same procedure with complications. The year's basic per case reimbursement rate is multiplied by the DRG weight to determine the Medicare reimbursement rate for a particular diagnosis-related group.

In July 1984, HCFA published the methods it proposed to use in determining the fiscal year 1985 payment rates. The methods included a controversial adjustment to the DRG weighting factors which had the effect of setting the average increase in payment rates at 4.2 percent. The hospitals had hoped for an increase of at least 6 percent.

The hospital industry appealed to the Congress and the President to intervene with HCFA in favor of a larger increase. In what is generally regarded as a political decision by the administration to maintain the hospital industry's support for prospective payment, HCFA announced amended rates that restored more than half the initial proposed reduction in DRG weights. The fiscal year 1985 payment rates were increased by an average of 5.2 percent.[16]

Underlying this controversy over the appropriate increase for 1985 in the DRG payment rates is a more basic conflict over the consideration which should determine the payment level. Some members of the administration believe that the DRG payment level should be increased only minimally, in order to limit Medicare outlays and thereby reduce the Federal deficit. Others—both in Congress and the administration—believe that payment should be set at levels which will continue to offer real incentives to hospitals to be efficient providers.

5. PROGNOSIS

During 1984, Congress was intent on reducing the large Federal deficits for the current year and years ahead. At the same time, President Reagan was intent on protecting the high level of spending for defense programs. The conjunction of these intentions directed Federal cost-cutting efforts at domestic programs, including Medicare. The Medicare Program is an attractive target for budget-cutters because it is costly—$63 billion (estimated) in 1984—and because it is widely believed to be unnecessarily expensive. The program pays for inefficient modes of health care delivery and for unnecessary or marginally effective care. During the 98th Congress, however, the Congress made only small cost reductions in Medicare outlays and no changes of note in entitlement coverage.

Federal, State, and private sector efforts to control health care costs are expected to be ongoing. The United States is already devoting nearly 11 percent of its resources to health care. Judging by international standards, this proportion is more than adequate to provide good health care for all Americans. Yet the proportion of the GNP spent on health care is still rising, and not all Americans have access to good health care.

During 1985, Congress is likely to consider changes in the hospital prospective payment system. The administration is considering proposals to freeze the DRG rates to delay or eliminate the shift from regional to national DRG rates. Others are reform of the Medicare method of paying for hospital capital costs and eliminating the DRG rate adjustments for medical education and indigent care costs. As part of its deficit reduction budget proposals, the administration is also expected to recommend proposals to (1) increase the premium to 35 percent of SMI Program costs by 1990; (2) index the part B deductible; and (3) impose a 1-month delay in eligibility.

Medicare's total costs, the size of annual cost increases and the large number of beneficiaries make it a certainty that Medicare will occupy a high position on the Federal policy agenda for years to come. Many reforms will be proposed and debated. Underlying all debate will be the unanswered question of whether it is possible to both contain Medicare costs and preserve quality of care and accessibility to care for older Americans. If the answer should be "no," there will be a political battle over which goal should be given the higher priority.

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[16] Demkovich, Linda. "Administration Boosts Medicare Rates to Keep Peace With Hospital Industry." National Journal, Sept. 15, 1984, p. 1721.

C. SUPPLEMENTAL HEALTH COVERAGE

From its enactment, Medicare was never intended to cover its beneficiaries' total health care expenditures; several types of services are not covered at all, others are covered to some extent but require the beneficiary to pay deductibles, copayments, and coinsurance. Medicare has consistently covered approximately half of the total medical expenses for noninstitutionalized, aged Medicare beneficiaries. Other health care expenditures remain to be covered by Medicaid, private supplemental health insurance, and other sources.

According to HCFA's NMCUE Survey of 1980, reported in March 1984, 67 percent of the aged Medicare population has private insurance in addition to Medicare. Of the $41.7 billion in total medical expenses incurred by noninstitutionalized aged Medicare beneficairies in 1980, Medicare paid 56 percent, patients and their families paid 18 percent, Medicaid paid 7 percent, and private insurance plans paid 15 percent. The likelihood of having private insurance in addition to Medicare increased among those with more education, and those with higher family incomes. Among the Medicare beneficiaries who had private insurance coverage, 82 percent had one private insurance plan, 17 percent has two or more, and 3 percent had three or more. Approximately 54 percent of the aged Medicare beneficiaries with private insurance had Blue Cross/Blue Shield plans, 45 percent had commercial insurance, and 6 percent were enrolled in HMO's or other prepaid health plans.

Private insurance purchased by the elderly generally concentrates its coverage on services which are covered by Medicare. For instance, in 1977, 97.6 percent of all privately insured elderly persons with Medicare coverage had supplemental coverage of hospital inpatient services, and 60 percent had coverage for ambulatory physicians services, outpatient diagnostic services, and care in skilled nursing facilities. On the other hand, relatively few Medicare beneficiaries had private insurance which covered services excluded from Medicare coverage: Only 40.6 percent had coverage for medicines prescribed outside the hospital, and only 4.1 percent had any dental coverage.

Group insurance often provides major medical coverage, requiring a substantial deductible but offering comprehensive coverage of remaining expenses. By contrast, about 75 percent of the elderly with individually purchased insurance held no major medical benefits. Group policy benefits were also superior to nongroup insurance in their coverage of fees exceeding the Medicare allowable charge. Group health insurance offers premium advantages, as well as coverage advantages, to the Medicare population. This is possible largely because employers held make group insurance affordable.

Medicare beneficiaries insured under group policies had a mean annual premium of $537, compared to only $201 for persons with nongroup insurance, but employers paid 58.1 percent of this expense on average. Thus, the out-of-pocket cost of private insurance for persons with group and nongroup insurance was virtually the same, $196 versus $197. Yet persons with group insurance were more likely to have coverage for services not covered, or partially covered, by Medicare than were persons with nongroup insurance. The lower cost of administering and marketing group insurance also helps keep premiums low in relation to expected benefits: In 1977, benefits paid by group health insurance plans sold to the general population averaged 90 percent of group premiums, whereas nongroup insurance plans paid out only 50 percent of their premiums in benefits. Thus, through lower administrative costs and high employer contributions, persons with group insurance typically obtained a higher range of benefits than persons with nongroup insurance.

1. ISSUES IN SUPPLEMENTAL COVERAGE

Concern about appropriate regulation for Medicare supplemental insurance policies, or medi gap policies, began to grow within a few years after the enactment of Medicare. Medicare has substantial gaps and limitations in its coverage of the aged's medical care expenses. Confusion with respect to these gaps on the part of persons eligible for Medicare, combined with their fear of financial ruin, has contributed to the sale of private health insurance plans.

Because of the rapid growth in the supplemental health insurance market, as well as the publicity that has surrounded some of its possible problems, Congress has for many years been considering what, if any, action it should take. The Senate Special Committee on Aging has been studying this matter since 1974. In 1978 and 1979, the Senate Special Committee and the House Select Committee on Aging held several hearings on the matter. This effort culminated in June 1980, when Congress enacted section 507 of Public Law 96-265, entitled "Voluntary Certification of Medicare Supplemental Health Insurance Policies" to establish a mechanism for voluntary certification of medigap policies. In accordance with the legislation sponsored by Senator Baucus, a supplemental health insurance panel [SHIP], consisting of the Secretary of Health and Human Services [HHS] and four State insurance commissioners or superintendents of insurance appointed by the President, was formed to determine whether regulations in each State meet or exceed the National Association of Insurance Commissioners [NAIC] model standards. As of November 1984, 46 States have adopted the NAIC model regulation into their own laws.

Four distinct, yet interrelated, potential problems have been the focus of much of the concern in this area. One major potential problem regarding medigap policies involves their efficacy, that is, whether the policies provide an equitable rate of return to the purchaser—as opposed to unreasonably low benefits relative to premiums paid—and whether they provide adequate coverage. Another problem in the medigap market is that of duplicative coverage. Congressional hearings have highlighted many cases where unsuspecting individuals were persuaded to buy dozens of unnecessary medigap policies that exhausted their financial resources. In most cases, however, duplicative coverage is more subtle. An individual may have two policies that have partially overlapping coverages or may have a few indemnity policies, each of which pays in case of hospitalization. Although the latter case does not constitute duplication of coverage from a technical standpoint, it is still of concern because it may imply that individuals are not spending their money as effectively as they could.

Another problem stems from lack of disclosure to beneficiaries of relevant information and the resultant low degree of informed choice. One of the basic tenets of a competitive market is that consumers have full information about the products they buy. In the medigap market, this condition may not be fulfilled for a variety of reasons. As a result, we would expect that consumers do not always make optimal choices in their decisions about whether to buy supplemental insurance and about the type and amount to buy.

Most of the publicity directed towards medigap policies has focused on the area of marketing abuse. These abuses, documented in congressional hearings, are attributable to both agents and the insurance companies. Although some marketing abuse clearly has existed, its extent has not been established because most evidence thus far has been anecdotal rather than scientific. Some examples of these abuses (not all of which can be examined in this study) are:

—Written and oral misrepresentation of what a policy covers and what gaps it fills.

—Inducing subscribers to cancel a previous policy and sign up for a new one, often with the result that preexisting condition exemption periods start anew and the agent collects an additional commission

—High-pressure or scare tactics.

—The passing of names among agents of likely individuals who will "buy anything."

—Deceptive or false advertising.

—Phony endorsements of policies.

—Improper claims handling, such as taking excesive time or not honoring valid claims.

Employment and labor organization-related group insurance policies and policies already in effect were exempted from the 1980 Baucus legislation. Therefore, mandated changes in the private insurance coverage of the Medicare population will probably occur gradually. Nevertheless, as more policies conform to the requirements of Baucus, more people will have at least partial coverage of long hospital stays and a greater percentage will have coverage for part B's 20 percent coinsurance, as well. Thus, one effect of the Baucus legislation will be a narrowing of differences in coverage between beneficiaries of group and nongroup policies, although differences will remain regarding the range of services covered and the levels of benefits for physician charges beyond the Medicare allowable fee. What effect the Baucus-mandated increases in coverage will have on premiums remains to be seen.

2. LEGISLATIVE ACTIVITY

No significant legislative activity occurred in the area of supplemental health coverage for Medicare beneficiaries in 1984.

D. HEALTH BENEFITS FOR FEDERAL RETIREES

The Federal Employees Health Benefits Program is the world's largest employer-sponsored health plan, providing voluntary health insurance coverage for 10 million Federal employees, retirees, and their dependents at a total annual cost of approximately $5 billion. Federal retirees who satisfy certain requirements can continue their coverage as long as they pay the employee share of the premium.

Under the program, enrolled employees and retirees are offered a choice of different health plans through which they can elect coverage. Premiums for the various FEHB plans are paid through contributions from the Government and from the enrollees. Under current law, the Government's share of the premium is equal to 60 percent of the average of the premium rate for the largest six plans (the "Big Six"), not to exceed 75 percent of the total premium for any individual FEHB plan. The enrolled employees and retirees pay the remainder of the premium cost, generally through deductions from paychecks or annuities.

1. ISSUES IN FEDERAL RETIREE HEALTH BENEFITS

Large FEHB premium increases in recent years, together with benefit reductions, have raised issues about the nature of the FEHB program, administration of the program, premium and benefit levels, and the amount of the Federal financial contribution to the program. In 1981, it was discovered that OPM projections for 1982 premium level increases (11 percent) were too low, due primarily to underestimates of inflation in health care costs and utilization of health benefits. In order to maintain plan benefits in 1982 at 1981 levels, premiums would had to have been increased by approximately 35 percent over 1981 levels. To avoid requiring such a large increase, OPM asked member plans to keep premiums as low as possible by adding such cost-sharing measures as increasing deductibles and coinsurance amounts, reducing coverage for certain benefits, and eliminating other benefits completely. With these benefit reductions, 1982 premiums increased approximately 17 percent over 1981 levels. 1983 premiums increased 18 percent over 1982 levels. Increases in the enrollees' share of the premiums were 22 percent in 1982 and 15 percent in 1983.

The rise in premium costs has slowed recently, lessening the sense of urgency behind proposals for FEHB reform: 1984 premiums increased 10 percent over 1983 levels, and 1985 premiums are expected to exceed 1984 levels by approximately 4 percent. OPM attributes this trend to the cost-sharing it introduced into FEHB plans in late 1981. However, other factors undoubtedly played some role in this decline in the growth of premiums. For example, increases in the cost of health care have slowed: CPI medical care costs in 1982 exceeded 1981 levels by 11.6 percent, 1983 saw an increase of 8.7 percent, and the two quarters of 1984 have averaged a

6-percent increase. Also, many enrollees are switching from high- to low-option plans in order to reduce their premiums. In fiscal year 1982, more than 200,000 people left the high-option Blue Cross/Blue Shield plan alone. More data will be needed to document the extent of this behavior. Cost sharing may decrease the Government's expenditure for FEHB but will not necessarily contain the rising costs of the program as a whole.

2. LEGISLATIVE ACTIVITY

Despite this slowdown in the rise of premiums, questions remain about whether the enrollees or th Federal Government should pay for premiums, and if both should contribute, then in what portion. H.R. 656, the "Federal Employees Health Benefits Reform Act of 1983," introduced January 6, 1983, would have increased the Government contribution from 60 percent to 75 percent of the average cost of the "Big Six" plans, and would have removed the present limitation that the Government contribution not exceed 75 percent of the premium for any individual plan. This bill would also have provided for a governmental differential, equal to 5 percent of the "Big Six" average, to be paid to a FEHB plan for each enrolled employee or retiree who is age 65 or older and is not entitled to participate in Medicare's part A program.

The administration's proposal to reform the FEHB program took a very different approach. It would have replaced the "Big Six" formula with a specified Government contribution amount equal to the average Government contribution in the preceding plan year, adjusted by the percentage change in the implicit price deflator for the GNP. Enrollees would be required to contribute the difference between the total premium cost for their FEHB plan and the fixed Government contribution. To the extent that the increase in the implicit price deflator of the gross national product (GNP) did not keep up with any increases in the FEHB premium costs, then enrollees would be required to pay an increasingly larger portion of the total premium cost. While neither of these proposals passed, their introduction served to highlight issues that will be addressed in the future.

Shifting the proportion of the premium paid by the Federal Government or by enrollees does not address the larger issues of cost containment for the FEHB program. Neither OPM nor the FEHB plans has aggressively pursued an extensive cost containment strategy.

Cost containment efforts in the future may attempt to improve coordination between Medicare and FEHB coverage for employees and retirees 65 and over. Several bills introduced in the last session of Congress contained provisions addressing this issue.

The administration's proposal, H.R. 3798, the "Federal Employees Health Benefits Reform Act of 1983," provided that, for a retired employee who enrolls only himself (and no dependents) in a FEHB plan, the Government's contribution to the premium would be limited to an amount equal to the premium for Medicare's part B. S. 1685, the "Federal Employees Health Plan Improvement Act of 1983," would have required Medicare-eligible employees and retirees to elect either to (1) enroll in a newly established Medicare supplementary plan (if the employee is age 70 or older), or (2) receive a Government contribution toward enrollment in a competitive medical plan (such as an HMO) which is authorized under section 1876 of the Social Security Act, or (3) receive a Government contribution toward enrollment of a Medicare-eligible's spouse in a FEHB plan. S. 2027, the "Federal Employees' Health Insurance Amendments of 1983," would have authorized each qualified plan under the FEHB program to offer one Medicare supplemental plan to Medicare-eligible individuals. None of these propsals were enacted during the 98th Congress.

E. HEALTH BENEFITS FOR RETIREES OF PRIVATE-SECTOR EMPLOYERS

One of the most important "aging" issues emerging in 1984 for private sector employers is the high cost of health benefits for older workers and retirees. These issues are not in themselves new, but recent Federal policy changes and financial accounting requirements have exaggerated the problems and made them more visible to employers. As a result, there is growing interest in collecting information about the problems and in seeking legislative solutions to them. Since the health benefits for older workers issues are covered thoroughly in chapter 4 (see section B, "Costs of Early versus Delayed Retirement"), this section will examine only retiree health costs as they relate to private employers.

Two major policy themes are at the root of the retiree health benefits issue. The first is the cost-shifting in the health care field created by the Federal Government's efforts in recent years to lower budget deficits. Cost-shifting has occurred in several direct ways. For example, recent tax code changes enacted as part of DEFRA have reduced the financial rewards for employers who prefund health benefits for their retirees. Providing these benefits, at least as part of a prefunded plan, will be more expensive in the future as a result of this policy change. Another example is the increased costs of providing health coverage for retirees caused by escalating cost-sharing under Medicare. For those employers who supplement Medicare coverage, any increase in premiums, copayments or deductibles under Medicare will cause a corresponding increases in employer costs. These direct cost increases are in addition to the overall cost-shifting which might occur because of tightened reimbursements under Medicare and Medicaid.

The second theme is the failure of the Federal Government to extend protection to retirees for their health and welfare benefits. This failure, coupled with current preemption standards under ERISA, have left most retirees unprotected in the event of an employer's inability (or refusal) to make good on promised postretirement health benefits. Future retirees need better assurances that they will receive their health benefits, but employers are strongly opposed to Federal requirements that they prefund these benefits or even that they be held responsible for them, because the spiraling costs of health care would make such requirements difficult to achieve.

1. BACKGROUND

There are no precise national figures on the number of retirees who have health coverage provided by their employers or their union. In a report issued by the House Select Committee on Aging on June 27, 1984, however, estimates of retirees coverage were provided. This report calculated that one out of every six elderly Americans is receiving a portion of their health coverage from an employer or union. When middle-aged retirees are included, the estimate is 5.5 million retirees and more than 3.8 million spouses are covered by private employer or union sponsored health plans.[17]

Most large employers and many smaller employers provide health coverage for early retirees, and most large employers provide coverage for retirees past age 65. Again, according to data provided by the House Select Committee on Aging, approximately 8 out of 10 large employers provide postretirement health coverage. The per capita cost of this coverage averages $3,000 to $5,000 annually for those under 65 and $600 to $1,500 for those over 65. The House report quotes former Secretary of HEW Joseph Califano as saying that, for the Fortune 500 companies, the unfunded liabilities for health benefits approaches $2 trillion, while the total assets for these companies is only $1.3 trillion.

2. ISSUES

(A) COST FACTORS AND COST-SHIFTING

The most critical issue in retiree health benefits for private payers is the rising costs of health care. As costs continue to spiral, employers are faced with an increasingly expensive and unpredictable situation with regard to their present and future retirees. Promises to retirees become more difficult to keep, especially when they must be made 10 or 20 years in advance.

Compounding the uncertainty created by rising health costs is the Federal Government's deficit control efforts, which in many cases result in cost-shifting of health costs to the private sector. Changes in tax treatment of health benefits and modifications in the medicare program, all have a direct impact on employers' costs of and willingness to provide postretirement health coverage. The changes in tax treatment alone, such as the "tax cap" proposed by the administration and various tax reform measures, have caused a near panic among employers and labor unions.

Another factor contributing to employers' concerns over retiree health benefits is the new accounting standards adopted by the Financial Accounting Standards Board, which require employers to disclose information about their postretirement health benefits. While this new requirement does not make any fundamental changes in accounting procedures, it is considered by many to be the precursor to more restrictive standards in the future. Such future standards might require employers to account for all promised health benefits for retirees as obligations on the books today.

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[17] U.S. Congress. House. Select Committee on Aging. "Corporate Retiree Health Benefits: Here Today, Gone Tomorrow?" Hearing, 98th Cong., 2d sess., June 27, 1984. Washington, U.S. Govt. Print. Off., 1984, p. 100.

This would mean an enormous shift in corporate thinking about retiree health benefits. It would focus attention on and it could put employers in a difficult position vis-a-vis applying for loans or engaging in mergers, and it may make employers choose not to offer any plan rather than disclose the existence of a large, unfunded liability.

(B) STANDARD FOR RETIREE HEALTH AND WELFARE BENEFITS

Currently, Federal law does not require that health and welfare benefits meet specific, minimum standards, such as those applied to pension plans. While the Employee Retirement Income Security Act (ERISA) stipulates minimum standards for pension plans, it does not cover retiree health, medical, surgical, or hospital benefits.

The dearth of Federal protection provided by ERISA is exaggerated in that, while ERISA does little to regulate employer-sponsored health plans, it preempts States from doing so as well. Thus, by refraining from entering into agreements with insurance companies to provide post-retirement health benefits for employees, employers can avoid the need to design a plan that meets state regulations. Instead, employers self-insure (that is, they do not prefund) in order to come under ERISA's scope and to thereby avoid State regulation and State taxation on insurance premiums, and to avoid participating in state catastrophic health insurance pools.

Another incentive for employers to self-insure exists in that general rules for terminating funded health and welfare benefit plans are specified in the tax code governing voluntary employee benefit associations (called 501(c)(9) plans or VEBA's). In general, plan assets must be distributed in the interest of participating employees. No such rules exist for unfunded health benefit plans.

This area may be ripe for reform. In 1984, Representative Brooks introduced H.R. 5475 to amend title I of ERISA to declare that unless otherwise specified, health and welfare benefits, life insurance, and supplemental pension benefits promised to retirees are provided for the life of the retiree and cannot be unilaterally terminated. And though no legislation has been introduced to date requiring prefunding of health benefit plans, many experts agree that some type of prefunding may be necessary to ensure that benefits will be available for future retirees.

3. LEGISLATIVE ACTIVITY

One provision included in DEFRA could have significant implications for the future of retiree health benefits. This provision modified the tax treatment of prefunded health and welfare benefits, or so-called VEBA's. (VEBA's are "voluntary employee benefit associations" and are established under section 501(c)(9) of the tax code). While it is true that only a small handful of employers establish prefunded accounts for their retiree health benefits, the mechanism used by these employers, and considered to be essential by them has been the VEBA.

Prior to DEFRA, VEBA's could be used in an unlimited way to set-aside funds for future obligations. To receive a tax deduction for these funds, the employer only had to certify that the funds would, in fact, be used to pay for benefits. DEFRA changed this by placing a cap on the amount of funds that could be set aside for tax purposes. Now employers are limited to setting aside no more than the total of their current expenditures for a particular benefit, plus 75 percent of that amount to account for future uncertainties. This 75-percent limit, according to benefit consultants, is far below the amounts needed to account for increases in the size of the retiree population and the rapidly escalating costs of health care. Some argue that 10 to 15 times current expenditures are needed to account for uncertainties.

This change in the tax treatment for prefunding of health and welfare benefits reflects the larger trend toward shifting the costs of such benefits back to the employer. Many employers claim as a result of the DEFRA change in VEBA's it is now unfeasible to guarantee any future retiree health benefits, at least through a prefunded mechanism.

DEFRA (section 560) calls for a study of welfare benefit plans by the Treasury Department to determine if minimum Federal standards are needed regarding participation, vesting and funding. A similar study was requested of the Labor Department by the House Labor/Management Subcommittee of the Education and Labor Committee. Further Federal action on this issue will await the outcome of these studies.

4. Conclusion

A crisis in employer sponsored retiree health benefits is brewing. Employer liability for such benefits will grow at an accelerated rate as the work force ages and health care costs rise. Employers face an increasingly uncertain future with regard to these benefits, especially as the Federal Government seeks ways of reducing deficits by shifting costs back to the private sector. The situation is no more certain for present and furture retirees, as they face retirement with no legal or statutory protections to ensure that they will receive their promised benefits.

The first step toward solving this emerging problem is to gather information about it. Fortunately, several surveys have been initiated and, along with the FASB reporting requirements, these should shed important light on the nature and extent of the problem. When the problem is better understood solutions can be proposed.

Chapter 8

LONG-TERM CARE

OVERVIEW

When a chronic illness strikes, most older Americans find that the long-term care services they need are not covered by Medicare, other public programs, or private medigap insurance. As a consequence, many elderly persons and their families pay the full cost of their care out-of-pocket. The cost of long-term care has become the single greatest threat to the financial security of older Americans.

Yet, no public or private group is prepared at this time to push for significant improvements in long-term financing and service delivery. The reluctance to implement new long-term care initiatives can be attributed to three factors. First, the 6 million older Americans who need long-term care are a relatively new phenomenon—with no tradition to help mobilize congressional interest or action. Second, the enormous costs of improving access to long-term care services for the elderly tends to deter interest in comprehensive legislative reform. Third, there is no current consensus on the best way to provide long-term care.

The task of meeting the long-term care needs of the Nation, in fact, is largely uncharted territory. In July 1984, the Senate Special Committee on Aging issued a study assessing the long-term care systems of Canada and Western Europe. The study found that, like the United States, none of the countries studied have comprehensive long-term care programs in place; the pattern, as in the United States, is that the supply of new services or an expansion of those that exist must be driven by immediate public demand. The report did show, however, that the institutional rates in long-term hospitals and nursing homes are generally lower in the countries with higher levels of cost-effective home care.

In the face of enormous Federal deficits and the impending insolvency of Medicare's hospital insurance trust fund, few observers expect the Congress to tackle a major new long-term care initiative in the near term. Any significant changes in this area are most likely to originate in the private sector: Several major commercial health insurers have already indicated an interest in pursuing the long-term care insurance market.

A. THE LONG-TERM CARE POPULATION IS HERE TO STAY

The absence of a national long-term care commitment can be attributed in part to the relatively recent emergence of a large chronically ill and disabled population. This new population has emerged mostly because of the decreases in mortality rates and the increases in life expectancy since the turn of the century.

In 1900, adults generally died from acute diseases. Influenza and pneumonia were the principal killers, followed by tuberculosis, then diarrhea, and enteritis. Few survived episodes of these diseases long enough to need care for their chronic conditions. Today, death from any one of these diseases is rare.

Whereas in 1900 only 1 in 25 persons lived to age 65 or older, today more than 1 in 9 Americans have celebrated their 65th birthday. More significantly, in 1900 there were approximately 772,000 persons between ages 75 to 84 and only 123,000 age 85 or older.[1] In 1984, there were about 8.8 million persons in the 75 to 84 age group and almost 2.6 million persons age 85 and over.[2] The 85-plus population has grown especially rapidly, up 165 percent from 1960 to 1982. This very old population is expected to increase fivefold by the middle of the next century. Overall, persons 85 and over are projected to be the fastest growing part of the older population. Americans are living longer—living to an age where the potential need for long-term care presents a new and serious national problem.

It is generally agreed that the incidence of chronic disease increases with age. Accompanying these increases in chronic illness is a greater need for in-home and institutional long term care services. The rising demand for long-term care with age is illustratedin table 1.

TABLE 1.—POPULATION AGE 65-PLUS IN NEED OF LONG-TERM CARE SERVICES (1980)

[In percent]

Age	Living in community	In nusring homes	Total
65 to 74	12.6	1.8	14.4
75 to 84	25.0	7.0	32.0
85 and over	45.8	16.2	62.0

Source.—Manton, Kenneth G. and Korbin Liu. "The Future Growth of the Long-Term Care Population: Projection Based on 1977 National Nursing Home Survey and the 1982 Long-Term Care Survey." March 1984.

Table 1 shows that while fewer than 1 in 7 people age 65 to 74 need long-term care, by age 85 and over nearly 2 in 3 need such services.

This relationship between advanced age and need for long-term care is also reflected in the nursing home population. According to the National Nursing Home Survey of 1977, 1 in every 100 persons age 65 to 74 lives in a nursing home, compared to 7 in 100 persons age 75 to 84, and 20 in every 100 persons age 85 and over.[3] Or, as Dr. Jacob Brody from the National Institute on Aging put it, "Americans are living longer: they have more healthy years and more unhealthy years."

Two major groups compose the current long-term care population: persons living in nursing homes and persons living at home. In 1985, 1.4 million older Americans will be living in nursing homes, about twice as many as 20 years ago. This number does not begin to reflect the large number of persons still living at home, waiting for an empty nursing home bed.

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[1] U.S. Senate Special Committee on Aging, Aging America, 1984.

[2] U.S. Bureau of the Census; Projections of the Population of the United States by Age, Sex, and Race: 1983-2080; Current Population Reports Series P25, No. 952.

[3] National Nursing Home Survey (1977), National Center for Health Statistics.

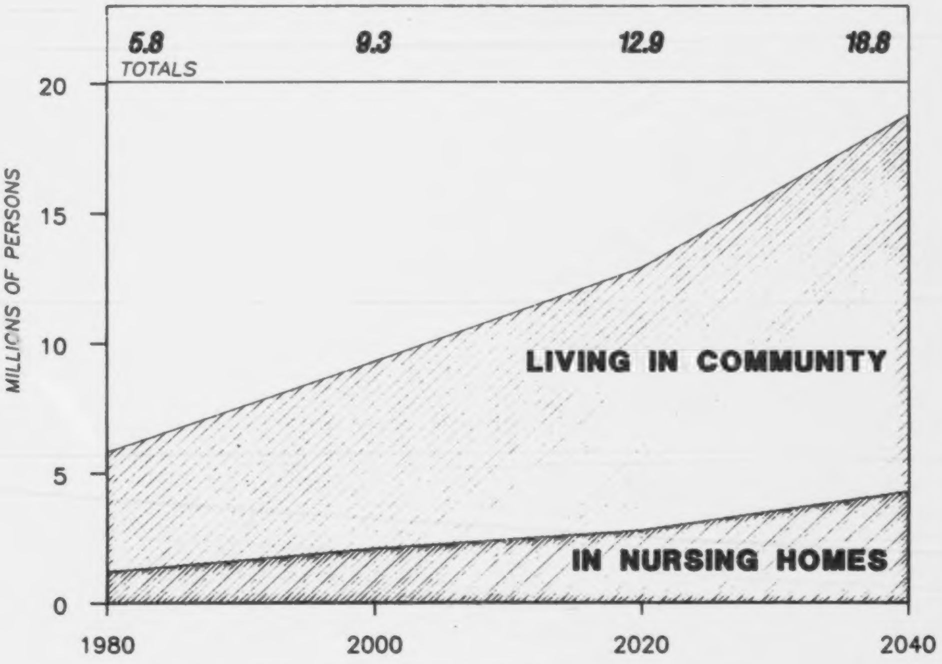
Estimates of the current noninstitutional long-term care population are often based on the incidence of functional limitations. A person's inability to manage either instrumental activities of daily living, such as preparing meals, or other activities of daily living, such as eating and bathing, is a good predictor of the need for long-term care. Using this definition, the 1982 long-term care survey projects that by 1985 5.2 million older persons living in the community will need some form of care—an increase of over half a million persons since 1980.[4]

In sum, approximately 6.6 million Americans age 65 and older will need long-term care in 1985, that is, almost 1 in 4 of the 28.8 million older Americans. Of these 6.6 million, 1.4 will be living in nursing homes and 5.2 million will be living in the community and will be in need of some home or community-based services. Since 1980, there has been a 14-percent increase in the number of older Americans in need of long-term care and the number needing these services is expected to grow at an even faster rate starting in the 1990's.

CHART 1

OLDER AMERICANS IN NEED OF LONG-TERM CARE

(1980–2040)



Source: 1982 National Long-Term Care Survey; and 1977 National Nursing Home Survey and Social Security Administration Projections

The nursing home population, for example, is expected to increase by 80 percent to 2.2 million persons in the year 2000 and will more than triple to 5.4 million persons by the middle of the next century. As chart 1 shows, the total institutional and noninstitutional long-term care population will grow to over 9 million persons by the year 2000, increasing to 12.9 million by the year 2020 and to almost 19 million persons by the year 2040.

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[4] 1982 National Long-Term Care Survey.

There are three major forces that account for the projected growth of the long-term care population. First, the mortality rate for people age 65 and over has declined, primarily because of the decline in deaths from heart disease. This means that many more people are now living to age 85 and joining the group most likely to need long-term care. Second, in the longer term, the post-World War II baby boom generation is aging and will reach old age shortly after the turn of the 21st century. Third, in the short run, Medicare's new prospective payment system may create additional pressure for long-term services because of earlier discharge from acute care settings.

On this last point, in New Jersey and Maryland, States with some prospective payment experience, there is evidence that the demand for nursing home and home health services has increased because Medicare patients are being discharged from hospitals with needs that require skilled care. Whereas the cost-based Medicare payment system once allowed hospitals to provide extended care to persons with chronic illnesses or conditions, the new Medicare prospective payment system may soon render that practice obsolete.

B. LIMITED PUBLIC AND PRIVATE OPTIONS FOR LONG-TERM CARE COVERAGE

1. Public Programs

An estimated 80 Federal programs contribute directly or indirectly to long-term care, but these publicly financed programs are not really designed to meet the long-term care needs of most older Americans. Medicare, Medicaid, the Older Americans Act, and the social services block grants each support some long-term care services, but only for varying population groups.

Medicare, for example, covers postacute home health care and skilled nursing facility care for eligible beneficiaries, but only for a limited period of time. Medicaid accounts for almost 90 percent of all public funds devoted to nursing home care, but only for persons living at or near the poverty line. Other programs carry a broad mandate to assist older Americans, but none are primarily targeted on long-term care.

In the absence of a comprehensive, national, long-term care policy, a melange of Federal and State programs and demonstration projects comprise the American long-term care service network. The following program descriptions highlight the severe gaps in and between the public programs that now leave many Americans vulnerable when a chronic illness strikes.

(A) MEDICARE

The Medicare Program, which insures 95 percent of all older Americans without regard to income or assets, is focused primarily on acute care, particularly hospital and surgical care and accompanying periods of recovery. Care in a skilled nursing facility [SNF] is covered, but only for 100 days and only following a hospital stay of at least 3 consecutive days and only for treatment on a daily basis related to a condition for which he or she was hospitalized. The SNF benefit, moreover, is subject to a daily patient copayment: currently $44.50 per day after the 20th day.

Medicare covers home health care, but only for a short period of time and only for treatment of an acute condition or for postacute care. Medicare does not cover either long-term or custodial care. To qualify for home health services, the beneficiary must be confined to the home, be under the care of a physician, in need of skilled nursing care, and the services must be provided by a Medicare certified home health agency. Treatment must be prescribed and reviewed by a physician.

There is no statutory limit on the number of home health visits covered under Medicare; but according to the Health Care Financing Administration [HCFA], home health care should generally be available for just a few weeks. HCFA's recent attempts to restrict use of the home health benefit have been the subject of congressional hearings and legislation, discussed in more detail later in this chapter.

While coverage of long-term care services is restrictive and limited, older Americans apparently believe that Medicare's coverage includes basic long-term care services. In fact, a recent survey by the American Association of Retired Persons found that of older persons surveyed, fully 79 percent believed that Medicare would pay for part, if not the entire cost, of their nursing home care.[5]

(B) MEDICAID

The Medicaid Program, which provides medical assistance for certain low-income persons, excludes most older Americans. Medicaid has nonetheless become the primary source of public funds for nursing home care. About 88 percent of all public funds for nursing home care is paid by Medicaid. Each State administers its own program and, subject to Federal guidelines, determines the Medicaid income eligibility standard.

State Medicaid programs are required by Federal law to cover the categorically needy, that is, all persons receiving assistance under the Aid to Families with Dependent Children [AFDC] Program and most persons receiving assistance under the Supplemental Security Income [SSI] Program. States may also cover persons who would be eligible for cash assistance, except when they are residents in medical institutions, such as skilled nursing facilities or intermediate care facilities.

In addition, States may, at their discretion, cover the medically needy, that is, persons whose income and resources are large enough to cover daily living expenses, according to income levels set by the State, but are not large enought to pay for medical care. These State variations mean persons with identical circumstances may be eligible to receive Medicaid benefits in one State, but not in another.

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[5] AARP, Long-Term Care Research Study, January 1984.

To control costs and to provide a range of community-based services to the Medicaid eligible population, many States have applied to the Department of Health and Human Services [DHHS] for 2176 Medicaid waivers. In 1981, Congress enacted legislation giving DHHS the authority to waive certain Medicaid requirements to allow the States to broaden coverage to include a range of community-based services for persons who, without such services, would require the level of care provided in a skilled nursing facility or intermediate care facility.

Services covered under the 2176 waiver include case management, homemaker, home health aide, personal care adult day care, habilitation, respite, and others. While this new waiver option has been enthusiastically received by the States, there is concern about the administration's support for the 2176 program. (This issue is discussed later in this chapter).

(C) SOCIAL SERVICES BLOCK GRANT

Title XX of the Social Security Act authorizes reimbursement to States for social services. Among other goals, the social service block grant [SSBG] is designed to prevent or reduce inappropriate institutional care by providing for community-based care, and to secure referral or admission for institutional care when other forms of care are not appropriate.

Although the SSBG represents the major social services program supported by the Federal Government, its ability to significantly support the long-term care population is limited. Because it provides a variety of social services to a diverse population, the title XX program has competing demands and can only provide a limited amount of care to the older population.

Prior to 1981, States were required to make public a report on how SSBG funds were to be used, including information on the types of activities to be funded and the characteristics of the individuals to be served. In 1981, these reporting requirements were eliminated. Data concerning the extent to which title XX now supports long-term care is therefore unavailable.

(D) THE OLDER AMERICANS ACT

The Older Americans Act [OAA] carries a broad mandate to improve the lives of older persons in the areas of income, emotional and physical well-being, housing, employment, civic, cultural and recreational opportunities, and social services. While the OAA thus funds a wide range of supportive services, in home services such as homemaker and home health aide, visiting and telephone reassurance, and chore maintenance have been given explicit priority by Congress. Each OAA area agency is required to spend a portion of its supportive services allotment on home care services.

It should be noted that the number of home care visits to older persons supported under the OAA represents only a small fraction of the amount under Medicare and Medicaid. The OAA services, however, are provided without the restrictions called for by Medicare and without the income tests called for by Medicaid; in some cases, OAA funds may be used to serve persons whose Medicare and Medicaid benefits have become exhausted or who are ineligible for Medicaid.

2. PRIVATE INSURANCE

While the public programs that cover long-term care services are restrictive, private long-term care insurance is virtually unobtainable.

(A) MEDIGAP POLICIES

Two in every three older Americans purchase supplemental medical insurance, or medigap. These policies are typically designed to supplement Medicare's coverage of acute-care costs, not long-term care costs.

To illustrate, some medigap policies cover the daily copayment from the 20th to the 100th day of an approved stay in a medicare SNF facility. Others provide coverage for skilled care, as defined by Medicare, in a certified facility for stays of 100 days to 365 days, or longer. The value of medigap coverage for long-term care, however, is very limited; these policies generally cover a very small fraction of total nursing home costs and an even smaller portion of home health or custodial care costs.

(B) LONG-TERM CARE INSURANCE POLICIES

There are approximately 50,000 individuals currently covered by long-term care policies.[6] At least 12 companies currently write individual long-term care insurance policies which are substantially more comprehensive then standard medigap policies. These policies offer indemnity benefits for 3 to 4 years of care in a licensed nursing care facility. In all cases, coverage continues after the need for skilled nursing care is fulfilled and the long-term care needs become custodial in nature.

There are several common features of the types of benefits offered by these companies. First, they all offer indemnity benefits, ranging from $10 to $50 per day. Offering an indemnity benefit, rather than paying the total costs of nursing home services, limits the insurer's liability and thereby reduces the risk of the policy to the insurer.

Second, all policies are offered with either a deductible or a reduced benefit for some initial period of time. This ensures that the more frequent short stays do not increase the cost of insuring the less frequent, but more expensive, long stays. In effect, these policies protect against catastrophic costs and are more like casualty insurance than traditional health insurance. Only individuals with extended stays are fully eligible for many plan benefits.

Third, all policies are to some extent oriented to a stay in a SNF or care in a facility with a full-time nurse. By excluding home care benefits, it is easier for the insurer to define the insurable event and thereby, to limit the insurer's liability.

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[6] Description based on report prepared by ICF, Inc., "Private Financing of Long-Term Care: Current Methods and Resources," phase I, submitted to the Office of the Assistant Secretary for Planning and Evaluation, DHHS, 1984.

These factors reduce the cost of the policies, but may also reduce both their desirability to many persons and their effectiveness in reducing overall costs. These characteristics of private long-term care insurance may also turn out to be an obstacle to efforts that are underway to stimulate a shift from institutional care to home care.

C. PUBLIC EXPENDITURES/OUT-OF-POCKET COSTS

The potential cost of improving access to long-term care services for the elderly is perhaps the single greatest deterrent to comprehensive reform. Both the Medicare and Medicaid Programs have witnessed rapid increases in long-term care costs. Efforts to reduce Federal deficits and to control the growth of entitlements have been assigned a higher priority than making long-term care services widely available.

1. Public Expenditures

Medicare expenditures for long-term care have generally been small. However, in recent years, spending for home care under Medicare has been growing and may soon become a target for spending reduction proposals.

In 1984, Medicare's contribution to SNF care was only $545 million, approximately 0.02 percent of total public and private spending for nursing home care and less than 1 percent of total Medicare spending.[7]

Both skilled nursing facility benefits and home health benefits may soon be included, however, in Medicare spending reduction proposals. Medicare payments for home health care comprise less than 3.1 percent of total program outlays;[8] for fiscal year 1984, total reimbursements for Medicare home health services were about $1.9 billion.[9] Table 2 indicates, however, that Medicare's home health benefit expenditures are the fastest growing component of the Medicare Program.

TABLE 2.—MEDICARE HOME HEALTH SERVICES

Calendar year	Total Medicare reimbursement (millions)	Percentage change	Total Medicare visits (millions)	Visits per 1 000 enrollees	Visits per user	Average charge per visit
1969	$81.1		8.5	424		$10
1970	62.7	−22.7	6.0	291		12
1971	57.2	−8.8	4.8	226		13
1972	66.2	15.7	5.2	241		14
1973	93.3	40.9	6.4	265		15
1974	138.6	48.6	7.9	340	20.6	17
1975	214.9	55.1	10.8	431	21.6	20
1976	296.7	38.1	13.6	520	22.7	22
1977	370.6	24.9	15.8	597	22.5	25
1978	442.8	19.5	17.6	639	22.5	27
1979	541.3	22.3	19.9	717	22.9	30
1980	662.1	22.3	22.4	788	23.4	33
1981	856.0	29.3	26.1	898	25.5	36

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[7] HCFA, unpublished data, 1984.

[8] Ibid.

[9] Ibid.

TABLE 2.—MEDICARE HOME HEALTH SERVICES—Continued

Calendar year	Total Medicare reimbursement (millions)	Percentage change	Total Medicare visits (millions)	Visits per 1,000 enrollees	Visits per user	Average charge per visit
1983[1]	1,268.1	33.2	30.6	1,037		
1983[1]	1,491.3	17.6				
1984[1]	1,720.9	15.4				
1988[1]	2,600.3	[2] 10.9				

[1] Projections based on fiscal years.
[2] Average projected annual growth from 1984 to 1988.

Source: HCFA/Bureau of Data Management and Statistics.

In contrast, expenditures for home care under Medicaid represent a small and static percentage of total program outlays. In 1984, Federal Medicaid expenditures for home health care were $270 million, accounting for less than 1 percent of total Medicaid spending.[10] In 1982, the last year in which these data were collected, home health benefits constituted more than 1 percent of total Medicaid expenditures in only nine States. One State alone, New York, spent 78 percent of all Medicaid home care dollars.[11]

Federal Medicaid expenditures for nursing home care in 1984 were over $10 billion, of which an estimated $4.8 billion were spent on SNF's and $5.7 billion for ICF's.[12] Medicaid financed 88 percent of Federal spending and 43 percent of total nursing home expenditures. Even though the elderly and disabled constitute only about one-third of the Medicaid eligible population, they account for more than two-thirds of Medicaid expenditures. More striking, nursing home residents comprise only 7 percent of all Medicaid recipients, but account for almost 50 percent of all costs.

Because Medicaid expenditures consume between 10 to 15 percent of State budgets, many States are working to control the growth of their nursing home population and their obligated Medicaid expenditures. As many as 26 States made changes in nursing home reimbursement policies to reduce costs in 1981 and 1982, with several States adopting a preadmission screening process and outright limits for the number of beds reserved for medicaid beneficiaries.

As chart 2 shows, the projected increases in nursing home expenditures will compound the difficulties currently experienced by States in covering nursing home care.

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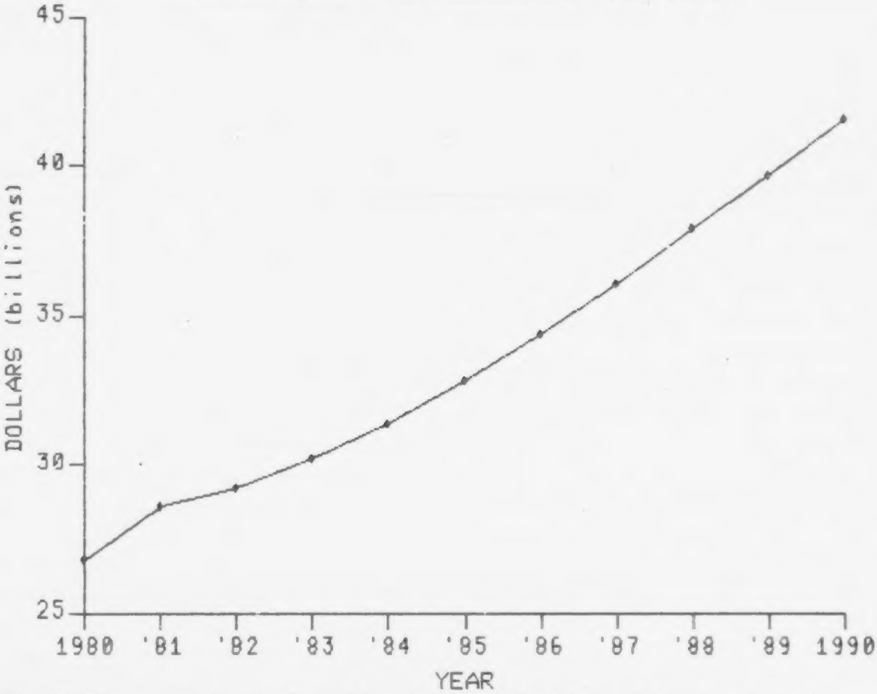
[10] Ibid.

[11] Medicaid program data branch, HCFA, DHHS, 1982.

[12] HCFA, unpublished data, 1982.

CHART 2

Projected National Nursing Home Expenditures
1980-1990 (1984 Constant Dollars)



SOURCE: HCFA unpublished estimates 1983-1990; Freeland and Schendler. "Health Spending in the 1980's: Integration of Clinical Practice Patterns with Management." HCFA Review, March 1984.

In 1984, total expenditures for nursing home care were an estimated $31.4 billion. Between 1965 and 1983, the total cost of nursing home care increased 7 percent above the rate of inflation, and is projected to go another 4.7 percent above inflation between 1983 and 1990. Backing out inflation, total nursing home expenditures will increase by more than 50 percent between 1980 and 1990.

2. Out-of-Pocket Costs

While the cost of long-term care expenditures represents an increasing share of Federal and State budgets, relatively few older Americans have access to publicly financed services. The cost of nursing home care and home and community-based care often falls on individuals and their families.

The cost of long-term care has usually been discussed in terms of public expenditures, because the costs to individuals were not documented. However, in September, new data were released at a hearing of the Senate Special Committee on Aging that describes the costs borne by persons who have no choice but to pay for the care they need out of their own pockets.

In fact, the vast majority of the chronically ill and disabled elderly population rely exclusively on informal support. Between 70 and 80 percent of these elderly persons living in the community who need long-term care receive all of the care they need from family and friends. The remaining 20 to 30 percent pay for their care themselves, or have some or all of their care paid for by private insurers, Medicare or Medicaid, and family members.

Home care is generaly believed to be a less expensive option for the elderly, but about 14 percent have out-of-pocket costs for home care that range from $360 to $1,680 per year, depending on the level of their disability.[13] These out-of-pocket costs are only for home care; they do not include other health related expenses, such as prescription drugs, or the other community-based services needed by many functionally impaired individuals.

The cost of community-based care pales in comparison to the cost of nursing home care. The price of 1 year in a nursing home ranges from $12,000 to $50,000; the cost at even the lower end of this range is beyond the resources of most older Americans. Thus, many elderly people must spend their entire savings and thereby become eligible for Medicaid soon after they enter a nursing home: Currently, between one-quarter and two-thirds of the nursing home patients who enter as private paying patients subsequently spend down their resources and become eligible for Medicaid.

D. LEGISLATIVE ACTIVITY IN LONG-TERM CARE

The 97th and 98th Congresses showed some interest, but took very little action, in the area of long-term care. Dozens of bills were introduced, yet only a few modest adjustments to existing programs were enacted.

1. Legislation Enacted in 1984

(A) MEDICARE REIMBURSEMENT FOR HOSPITAL-BASED SKILLED NURSING FACILITIES

The Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA] required the Secretary of the Department of Health and Human Services to establish a single payment limit for both freestanding and hospital-based skilled nursing facilities [SNF's], effective October 1, 1982. Prior to that time, separate limits were established for these two types of facilities because the operating costs of hospital-based facilities were typically much higher than those of freestanding facilities. In the Social Security Amendments of 1983, the effective date of the single payment limit was postponed until October 1, 1983.

In the Deficit Reduction Act of 1984 [DEFRA], the Congress set limits for freestanding facilities at 112 percent of the mean operating costs. Separate limits for hospital-based facilities were set at the freestanding facility limit plus 50 percent of the difference between the freestanding facility limit and 112 percent of the mean operating costs for hospital-based facilities. Overhead costs could be recognized as an add on to the limit. Exceptions could be granted based upon case mix or circumstances beyond the control of the facility.

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[13] 1982 National Long-Term Care Survey.

DEFRA also requires the Department of Health and Human Services [DHHS] to submit reports to Congress concerning both the impact of the single rate provision on hospital-based SNF's and also prospective payments for SNF's.

(B) HOSPICE

In DEFRA the Secretary of DHHS was given the authority to waive the nursing care core service requirement for hospices located in rural areas, which were in operation on or before January 1, 1983, and which have demonstrated a good-faith effort to hire their own nurses.

Later, H.R. 5386 was enacted to increase the rate paid by Medicare for routine hospice care. This measure was agreed to largely in response to testimony from hospice providers who described the inadequacy of the established rate at a hearing before the Senate Finance Committee's Health Subcommittee on September 17, 1984.

(C) HOME HEALTH

DEFRA now permits a physician who has a financial interest in an agency, which is a sole community home health agency, to certify and order a plan of care for patients served by that agency. Prior to enacting this amendment, physicians with a significant ownership interest or a significant financial or contractual relationship with the home health agency were prevented from performing these functions.

Another provision in DEFRA requires a beneficiary copayment of 20 percent of reasonable charges to apply to the purchase of all durable medical equipment, including that which is provided by a home health agency. Under prior law, Medicare paid 100 percent of the reasonable charges for medical devices provided by home health agencies.

(D) SOCIAL/HEALTH MAINTENANCE ORGANIZATIONS [S/HMO]

DEFRA required the Secretary to approve specific waivers for S/HMO projects at four sites within 30 days of enactment. Congress required waiver approvals to prevent OMB from delaying or denying the waiver requests and to encourage HHS to implement the mandated demonstration projects on a timely basis.

2. 1984 Legislative Proposals

Only two proposals to improve access to home and community-based services were taken up in the Senate. In the end, both failed to be enacted because of overriding budget considerations.

(A) INTERMITTENT CARE

The only long-term care bill to pass in the Senate was concerned with the definition of the "intermittent care" standard for Medicare's home health benefit. Legislation and congressional hearings highlighted the need to clarify the definition of intermittent care and to correct what appeared to be arbitrary, inconsistent, and overly restrictive decisions concerning this Medicare benefit.

According to home health providers and intermediaries, problems with reimbursement for intermittent care were the result of a HCFA transmittal sent to fiscal intermediaries in 1982. The transmittal had the effect of restricting access to home health care. Under current law, eligible Medicare beneficiaries can receive unlimited home health visits as long as they are part time or intermittent, provided by or under the supervision of a registered nurse, and ordered by the patient's physician. The HCFA transmittal stated that Medicare would pay only for part-time medically necessary and reasonable skilled nursing care or home health care services 7 days a week for only a short period of time—2 to 3 weeks.

Several problems were created by this transmittal. First, some beneficiaries were considered ineligible for any home health benefits if they would need care for more than 2 to 3 weeks; others who received care for more than 3 weeks had their payment claims denied retroactively. Many were unable to get coverage for the home health care they needed beyond the 2- to 3-week period. Second, when physicians prescribed daily home care for their patients for a short period of time, payment was denied in some cases, but not others, depending upon interpretations of daily need. Third, administration of the home health benefit had become inconsistent and somewhat arbitrary. Beneficiaries with illnesses were receiving care for an extended period of time in some regions of the country, but not in others.

Representative Henry Waxman introduced H.R. 3616 and Senators John Heinz, Lloyd Bentsen, and John Glenn introduced S. 2338 to correct the intermittent care problem. The Waxman bill would provide nursing care and home health services for up to 90 days, with physician certification and the 20 additional visits beyond the time when the patient qualifies under Medicare for skilled care. The Heinz-Bentsen bill would provide for up to 60, rather than 90 days of home care and did not include the additional 20 visits. A modified version of S. 2338 was passed by the Senate in April 1984 as part of H.R. 4170. However, the provision was dropped in conference with the House, probably because of its estimated annual cost of $30 million.

The conferees did, however, express concern about the lack of uniformity in the interpretations of existing law and the varying interpretations of intermittent care by intermediaries. The language of the conference agreement emphasized that care provided should be governed only by the medical need of the beneficiary. Furthermore, to improve the consistency in the administration of the benefit, the conferees agreed to a provision for moving within 3 years to no more than 10 regional home health intermediaries—rather than the 47 as now provided under current policy.

(B) THE HOME HEALTH BLOCK GRANT

The only other long-term care proposal to see action in the 98th Congress was S. 1531, a bill introduced by Senator Hatch to establish a new block grant to allocate funds to States for home care without some of the eligibility restrictions required by either Medicare or Medicaid. Funds would be distributed on the basis of the ratio of the total number of elderly individuals residing in a State to the total number of elderly individuals in all States. States could use the funds to coordinate existing services to eliminate duplication and to provide needed home and community-based services.

The provision was adopted in committee, but later dropped in response to the administration's opposition. However, Senator Hatch did receive a letter of support from OMB Director David Stockman:

> We share your belief that home health care providers have played a central role in bringing sound health and related care to many who are homebound. Effective use of home health services can lead to less institutional care and a reduced demand for expensive nursing home and hospital health services. We are pleased to work with you in a joint effort to design and structure a more integrated and effective approach to home health services.

It is anticipated, given the OMB Director's explicit commitment to the chairman of the Labor and Human Resources Committee, that legislation will be reintroduced in the 99th Congress and some action may be viewed more positively by the administration.

E. ISSUES IN LONG-TERM CARE FOR 1985 AND BEYOND

1. Medicaid

(A) MEDICAID 2176 HOME AND COMMUNITY-BASED WAIVERS

Section 2176 of the Omnibus Budget Reconciliation Act of 1981 authorizes the Department of Health and Human Services Secretary to waive Medicaid statutory requirements in order to enable a State to cover a wide range of home and community-based care [HCBC] services. These waivers are designed to provide States with greater flexibility and the ability to test new approaches in the delivery of Medicaid services.

Perhaps the major significance of this legislation is that for the first time, a range of both health and personal care services as well as case management are specifically authorized in legislation, thereby giving legislative recognition to the social as well as the medical aspects of long-term care under the aegis of the Medicaid Program. The waivers are granted under an initial 3-year term to cover care for the aged and disabled, mentally retarded, and the mentally ill who have been determined to otherwise require skilled nursing facility [SNF] or intermediate care facility [ICF] services.

States have responded enthusiastically to the waiver option. As of August 31, 1984, HHS had approved 75 HCBC waivers thus far submitted by 44 States, for the aged/disabled and mentally retarded, and mentally ill populations. The response by over 90 percent of the States indicates a strong effort to develop alternatives to nursing home use and to control costs while assisting the elderly and disabled in finding the most appropriate levels of care.

In 1984, however, several issues emerged which threaten to shut down the waiver option as an alternative to institutional care. First, several States have experienced lengthy delays in gaining approval for their waivers, which have thrown off their State budget planning and implementation plans. Second, HCFA has asked some States to meet arbitrary cost reductions which are not required by statute. (By law, waiver costs must not exceed the State's per capita Medicaid costs.) This fiscal squeeze has cast considerable doubt on the ability of States to provide adequate services for their needy clients. Also, some States have been required to include in their comparative cost calculations non-Medicaid Federal costs, such as AFDC, SSI, and food stamp payments.

These problems stem from a basic ambiguity about what Congress intended when the 2176 waiver option was enacted. Consequently, in the past year OMB has been able to emerge with greater control over the waiver process by focusing attention on the fiscal implications of the HCBC waiver program, rather than on the overall strategy of providing appropriate health and social services.

Recently, for example, OMB has stressed the need to ensure cost savings to the Medicaid Program by deinstitutionalizing, rather than expanding services for persons who would otherwise be in an institution. The States, however, regard the waiver option as a means to provide more appropriate, quality care to the institutionalized and at risk persons in the community at a cost savings to the States and Federal Government.

The waiver approval and renewal process is now being prolonged because waiver applications are examined much more closely by both DHHS and OMB than was the case during the initial 2 years of the program. In fact, only nine regular 2176 waivers were approved in 1984. Further, DHHS's failure to publish final regulations on the 2176 waivers has triggered considerable concern and uncertainty regarding States' statutory obligations to OMB/HHS and also what the OMB/HHS interpretation of the law will be.

Given the States' enthusiastic response to the waiver option, and the obstacles to its continuation, the future of the waiver program may be an issue for congressional attention in 1985.

(B) DISCRIMINATION AGAINST MEDICAID BENEFICIARIES

Any discussion of the quality of long-term care presupposes access. Yet, in October 1984, the Senate Special Committee on Aging held a hearing to highlight a serious problem of national magnitude: Many nursing homes are found to be actively discriminating against Medicaid beneficiaries. The committee's investigation demonstrated that, in some areas, up to 80 percent of the federally certified nursing homes have discriminated against Medicaid beneficiaries. According to Chairman Heinz, these acts are "morally reprehensible as well as criminally illegal."

The vast majority of nursing homes, over 13,000, are federally certified for Medicaid patients; that is, the Federal Government has inspected these facilities, found them to meet minimum standards required by Federal law, and certified them to admit patients eligible for Medicaid. Admission practices and prices for Medicaid patients are then regulated by Federal law.

Federal law does not require certified nursing homes to accept a minimum number of Medicaid patients. Nor does it prohibit them from refusing to admit a patient because he or she is a Medicaid recipient. However, when a federally certified nursing home does admit a Medicaid patient, that nursing home may not require the patient or patient's family to sign a private pay contract. Such homes are also prohibited from requiring a cash payment or donation up front before admitting a patient eligible for Medicaid. Moreover, the nursing home may not demand additional payment above the amount paid by Medicaid in return for allowing a private pay patient to remain in the facility once he or she has become Medicaid eligible. Each of these practices is a felony under Federal law, punishable by a fine of up to $25,000 and a prison term of up to 5 years.

To illustrate the problem uncovered by committee investigators, one witness testified that when her mother became eligible for Medicaid, the nursing home administrator, told her that her mother would be evicted unless the family continued to pay the $1,600 monthly private fee for a full year. Another witness told of being required to sign an 18-month private pay contract in order to get his 81-year-old mother into a nursing home in New York. Both of these cases demonstrate the types of discriminatory practices against Medicaid eligible nursing home residents.

While individuals who are victims of these illegal practices cannot be legally forced to comply with such contracts, many nonetheless sign—promising to pay private rates or make cash donations. They do not have private right of action allowing them to go into court as the plaintiff and sue the nursing home for its violation of the law. Instead, the victim must assert his rights defensively, after he is sued by the home for failing to comply with what is essentially an illegal contract. This remedy is not entirely satisfactory because it often leaves patients feeling as though he or she must agree to the illegal contract in order to gain admittance and then to break that contract in order to exercise their rights.

The Federal Government has few satisfactory recourses to stop such discriminatory practices. Under present rules it could decertify a nursing home, thereby barring the home from participating in the Medicaid Program or from accepting Medicaid recipients or money. Such a sanction, however, may be as great a disservice to the beneficiaries as it is to the home—especially in areas with serious shortages of nursing home beds for Medicaid patients. There is one alternative to the decertification process created by Congress in 1980, that is, a moratoria imposed on admissions by the Federal Government on homes which violate their obligations to comply with Federal law. However, at the time of the hearing, the DHHS had not issued the regulations in final form.

[NOTE.—Following the hearing, Senator Heinz met with DHHS Under Secretary Charles Baker, who assured the committee chairman that the regulations would be published by the end of 1984 and that DHHS would step up enforcement of other Federal laws signed to protect the elderly poor and disabled from discriminatory practices.]

2. MEETING THE LONG-TERM CARE NEEDS OF THE AGING VETERAN

The proportional growth in the number of elderly veterans is expected to greatly exceed the growth rate of the total 65-plus population and the rapid growth occurs much sooner. The number of veterans aged 65 and older—now approximately 4 million—is expected to double by 1990, and to triple by the year 2000 with the aging of World War II and the Korean war veterans. By 1990, 1 of every 2 American men older than 65 will be eligible for VA benefits. By the year 2000, two-thirds of all American men over 65 will be veterans. Under current eligibility rules, all of these veterans will be eligible for free medical and long-term care from the VA.

This aging trend among the veteran population poses a serious challenge for the VA health service delivery system. While not all elderly veterans will turn to the VA for medical care, the demand for care is likely to increase with the number of aged veterans, reflecting not only their increased number but also the higher utilization rates associated with age. Demand for VA services could be even greater if other medical care programs, such as Medicare and Medicaid, are modified to decrease services or increase patient cost-sharing requirements.

The VA's greatest challenge may lie in providing adequate care for the veterans 75 and older. These persons consume the greatest amount of resources on a per capita basis. Currently, 21 percent of the Nation's aged veterans are between 75 and 84 years of age. By the year 2000, 3.45 million, or 38 percent of all aged veterans will be between the ages of 75 and 84 and, in just 20 years, between 1980 and the year 2000, the number will increase by 439 percent.

If elderly veterans request and receive care at the current utilization rates, the real costs of providing veterans' health care could double within the next decade. Current trends indicate that total outlays for VA medical care, excluding construction costs for new or expanded facilities, will total approximately $44.2 billion over the 1985 to 1989 period.

Congress has a number of options that it can be expected to face concerning questions associated with the provision of VA health and long-term services in the future.

One possible response to the expected increased demand is to increase the supply of services by expanding VA facilities. However, since the population of older veterans, and all veterans, will decline after the turn of the century, some think it necessary to avoid creating what will soon become an excess capacity. Instead, they propose using existing VA facilities as efficiently as possible.

Another option would be to restrict eligibility for VA care or reduce the scope of VA benefits by limiting VA coverage to only those veterans with service-connected conditions. The VA estimates that 2.2 million veterans, or only 32 percent of those being treated in VA hospitals, suffer from service-connected problems.[14] VA hospitals, however, may find it infeasible to stay in operation serving only this limited portion of the veteran population. Such a change might make it necessary to reimburse veterans with service-connected problems for the health care purchased in the private sector.

Some contend that the VA should not operate a separate medical care system; that it is too costly, and it exacerbates the problem of unused capacity in public and private hospitals and nursing homes. They maintain that VA services could be integrated in some way with private services while still adequately serving veteran patients. Others argue that, while the VA could satisfy a higher proportion of the demand for nursing home care by contracting with community nursing homes or by increasing grants to States to build more State veterans' homes, it should nevertheless be preserved as a separate system. Proponents of this view point out that this country has historically honored its moral obligation to those who served in the armed services, and that this obligation is not one on which we should default. They further argue that a substantial number of veterans suffer from chronic diseases, such as alcoholism, from which they can really not expect to recover and that VA hospitals provide long-term care that these vets could not afford elsewhere. Many proponents of a separate VA health care system fear that the abolition of this system would foreshadow a lessening of Federal commitment to protect the availability and quality of veteran health care.

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[14] "Caring for the Older Veteran," Veterans' Administration, July 1984, p. 16.

These issues will inevitably be addressed as the aging veteran population begins to have a considerable impact on the Federal budget in the coming years. Furthermore, as veterans turn 65 and become eligible for both VA and Medicare benefits, total Federal costs may rise. It is not clear at this time how this will affect VA, Medicare, or Medicaid costs without knowing the extent to which veterans will use each program.

These problems lie ahead, however. In 1984, the legislative agenda was quite narrowly framed. Congress did enact the Veterans' Administration Health Care Amendments of 1984, which addressed, in part, the needs of elderly veterans. This new statute makes permanent the authorization of appropriations for the VA's Geriatric Research, Education and Clinical Center [GRECC's]. GRECC's support research into diseases and disabilities of the aged, improve health care for patients, and the education of health professionals. This authorization had been due to expire in September 1984. Also, legislation was introduced to require the VA to clarify its policy concerning treatment of persons with Alzheimer's disease; however, it was not included in the compromise agreement reached by the House and Senate conference committees.

The administration is expected to propose a plan that would enable veterans with service-connected disabilities to continue to receive free VA health care, while veterans earning above $15,000 a year would not be eligible for free VA care for nonservice-connected disabilities.

3. Research

Biomedical research is one of the most fundamental, yet often overlooked, ways to reduce the need for long-term care. The Federal Government's substantial investment in biomedical research for nearly four decades has resulted in America's unquestioned preeminence in science and health. But, it is persons suffering from acute, not chronic diseases and disabilities that have benefited immeasurably from advances made in treatment and diagnostic techniques.

The National Institutes of Health [NIH] support extensive research on diseases of particular importance to the elderly. These include: cancer, diabetes, heart disease, stroke, organic brain disorders, arthritis, hypertension, cataracts, neurological disorders, and digestive diseases. The National Institute on Aging [NIA], the newest institute at NIH, focuses its research funds on easing or eliminating the physical, psychological, and social problems which affect the elderly population. Areas of biomedical and clinical research include studies on the genetic determinants of aging; the etiology, diagnosis, and treatment of Alzheimer's disease; osteoporosis and osteoarthritis; problems of drug use by the elderly; the impact of nutrition on aging; depression; sleep disorders; and exercise physiology in older persons.

In the past few years, funding for NIH activities has increased steadily in response to strong congressional support for biomedical research and its commitment to maintain America's preeminence in science. Funding for NIH has generally exceeded the Reagan administration's proposed budget levels. the administration's 1985 budget request, for example, proposed reducing by 5 percent funding for new and competing renewal awards as well as noncompeting continuation awards. Congress rejected this proposal and continued funding for these research grants at an average of 98 percent of their original level.

In 1984, the Senate Appropriations Subcommittee on Labor, Health and Human Services and Education noted particular concern regarding the administration's fiscal year 1985 budget request for NIH. Although the administration requested a 14-percent increase in research spending, the largest increases were slated for the Departments of Defense and Energy, with only a 2-percent increase requested for NIH. The subcommittee found:

> That level of funding would severely reduce the number of approved and funded research projects; require significant cuts in direct costs for all project grants; reduce the amount of research that would be performed by our scientists; ignore the need for continued training opportunities that serve to attract the keenest young minds in America to biomedical research; severely handicap ongoing clinical trials and leave some 40 new clinical trials unfunded. The administration's budget request totally ignores deteriorating research facilities and the shortfalls and obsolescence in scientific instrumentation and equipment.

Congress responded by approving an appropriation of $5.1 billion for NIH in fiscal year 1985, an increase of $600 million over the 1984 appropriation.

For the past 3 years, Congress has paid increased attention to the serious and growing problems related to Alzheimer's disease. Persons suffering from Alzheimer's disease require extensive long-term care services. This progressive, degenerative brain disorder affects at least 2.5 million persons, and is responsible for 120,000 deaths each year. Research on the cause and treatment of Alzheimer's disease is supported by the National Institute on Aging, National Institute of Neurological and Communicative Disorders and

Stroke, National Institute of Allergy and Infectious Diseases, and the National Institute of Mental Health.

Several congressional hearings were held during the 98th Congress to examine the overwhelming demands imposed by Alzheimer's disease on long-term care services and facilities. Given the growing numbers of elderly, especially the population age 85 and older who are at greater risk of developing this disease, the demands on long-term care services over the next several decades will be staggering. Alzheimer's disease is a major predictor of institutionalization, accounting for as many as 50 percent of the elderly in long-term care settings. Although a large number of older persons with Alzheimer's reside in the community, often with family members, both groups are affected by significant gaps in the long-term care system in meeting the special needs of Alzheimer's patients and their families. The tremendous national effort to find a cure and treatment for Alzheimer's was precipitated largely by a greater understanding of the financial and emotional toll of the disease on family caregivers, as well as on victims.

Last year, Department of Health and Human Services' Secretary Heckler established a departmental task force on Alzheimer's disease in an effort to pool the Nation's scientific and medical resources in a coordinated, comprehensive study of this disease. The task force report was released in September 1984 amid accusations that the Department had avoided the critical question of expanding current long-term care services to include the care of Alzheimer's patients. The report included recommendations for further clinical and behavioral study on Alzheimer's, and outlined the Department's plans to support the development of family support groups.

In the past 2 years, Congress has increased dramatically the funding for Alzheimer's research. In fiscal year 1984, Congress appropriated $36 million for research activities, and provided NIA with an additional $3.5 million to fund up to five Alzheimer's disease research centers. The grantees were announced in September 1984 and include: Harvard Medical School/Massachusetts General Hospital in Boston, MA; the Johns Hopkins Medical Institutes in Baltimore, MD; the Mount Sinai School of Medicine in New York, NY; the University of California, San Diego, CA; and the University of Southern California, Los Angeles, CA. The enacted fiscal year 1985 Labor-HHS-Education appropriation bill includes $56 million for Alzheimer's research and provides an additional $5 million to establish five more research centers. This funding level will allow NIA to maintain the same rate of growth in basic research grants as was supported in fiscal year 1984.

A 3-year deadlock on biomedical research legislation was broken in 1984 when Congress approved a 3-year extension of research activities at NIH [S. 540]. The legislation would have established two new institutes at NIH—the Institute of Arthritis and Musculoskeletal and Skin Diseases and the Institute of Nursing—but it was vetoed by President Reagan. The administration claimed that the new Institutes would be costly and unnecessary. Advocates had argued that separate Institutes would provide more effective organizational structure for improved management of these research programs.

4. Geriatric Training and Education

Essential to effective, high quality, long-term care is an adequate supply of well-trained health care providers, including physicians, physicians' assistants, nurses, dentists, social workers, et cetera. For decades, the Federal Government has supported the education and training of health care professionals by providing financial assistance through a variety of Federal and State agencies. This support was relatively unrestricted and unfocused; that is, it aimed at increasing the numbers of all types of health care professionals. By the mid-1970's, this generalized effort had proven successful. Congress was able to focus on particular problem areas in the supply of health care professionals, such as geographic and specialty maldistribution. Federal financial support was then focused on special projects; for example, more authorities were established by Congress to train primary care physicians, minority students, physician assistants, and so on.

To date, the Federal Government has yet to focus significant support on education and training in geriatric care. In an effort to assess both the needs of the aging population and the ways in which the Federal Government could support needed education and training, the NIA released its "Report on Education and Training in Geriatrics and Gerontology" in February 1984.

This report documents the shortage of and the projected need for personnel with training in geriatrics and gerontology. The report states that fewer than 300 medical school faculty members are invovled in teaching some aspect of geriatrics today, but at least 1,350 will be needed to adequately staff medical schools in the year 2000; 8,000 geriatricians and 1,000 geropsychiatrists will be needed in 1990; the number of registered nurses in nursing homes and extended care facilities will have to double from 77,000 in 1980 to 150,000 in 1990; and the number of community health nurses with special training in gerontology and geriatric nursing will have to double, from 53,000 in 1980 to 106,000 in 1990. Similar increases will be needed in geriatric nurse faculty, geriatric dentistry faculty, geriatric social workers, social work faculty, social gerontologists, and gerontological aides, and others.

Current resources to provide education and training in geriatrics and gerontology are very limited. The NIA report estimates that only about 1 percent of expenditures for training and research in the health field is concerned specifically with aging and the aged. Overall obligations for Department of Health and Human Services training programs in geriatrics and gerontology amounted to about $27 million for 1984.

At present, there is no effective coordinated Federal approach to initiate, expand, and improve these types of education and training activities. Thus, not only is additional funding needed, but also a method of coordinating efforts in order to provide fast results without wasteful duplication of efforts.

A number of bills introduced in the 98th Congress addressed the need for funds and training in geriatrics and gerontology. The Health Professions Education Amendments of 1984 [S. 2559], introduced by Senator Hatch, included a provision that would revise section 788 of the Public Health Service Act [PHSA] to provide grants and contracts for training in geriatrics and long-term care. H.R. 5602, introduced by Congressman Waxman, contained a 2-year extension of the health professions education programs, established a new program of grants to schools of public health to develop or expand geriatric programs, and revised and extended the existing curriculum development program for training in geriatric care and long-term care. These bills were merged into S. 2574, the Nurse Training Amendments of 1984 which, as approved by the House and the Senate, would have revised section 788 of the PHSA to expand the number and types of health professions schools eligible to receive aid under this provision, and would have established a separate authorization for geriatric training support, among other things. This bill was vetoed by the President who felt that the separate authorization levels were too high and preferred a single authorization for all of title VII with discretion for the HHS Secretary to distribute funds among different programs.

A final bill, S. 3035, the Geriatric Manpower Training and Education Act of 1984, was introduced by Senator John Heinz specifically as a response to the enormous shortage of health personnel trained in geriatrics and gerontology to meet the needs of present and future generations of older Americans. This bill would authorize a nearly threefold increase in funding over a 5-year period to support expansion of geriatric and gerontology education and training programs within the AoA, NIA, NIMH, and the Health Resources and Services Administration [HRSA]. This bill is expected to be reintroduced during the 99th Congress.

F. PROGNOSIS FOR LONG-TERM CARE IN THE 99TH CONGRESS

Barring an extraordinary and unanticipated surge of public interest, congressional action on long-term care during the 99th Congress is not likely. Issues may well be discussed, but any legislation is likely to be narrowly focused on proposals to improve cost effectiveness.

Medicare's method of payment for SNF's and home health care is one issue in which some Members of Congress and representatives of the administration have already expressed an interest: Establishing prospective payment for skilled nursing facilities and home health care, they believe, may help to foster cost control and help to target services to persons with specific service needs. Others, however, think too little is known to implement such a radically new financing system and argue it may result in problems with quality of and access to care.

Medicaid 2176 waivers may also be a topic for debate during the 99th Congress. States have reported increased difficulty in obtaining or renewing the community-based waivers. It seems DHHS and OMB have imposed new and more restrictive standards requiring cost effectiveness and that there is, apparently, some disagreement as to what Congress meant by cost effectiveness in the first place.

Proposals concerning the financing and delivery of long-term care are likely to resurface in the 99th Congress. Senator Heinz, for example, may reintroduce S. 1614, a bill to pool Medicare and Medicaid dollars in order to provide the full range of acute and long-term care services to the dually eligible population. The bill uses a capitated payment system to limit the financial risk to Medicare.

Another bill, S. 1244, introduced in 1983 by Senators Packwood, Bradley, and Heinz, also uses a capitation payment system to provide long-term care benefits. Congressman Conable's bill, H.R. 5726, would establish a voluntary long-term care program for enrolled aged and disabled individuals to be financed by premium payments by enrollees together with contributions by States. Other bills would provide tax credits to offset some costs of families who meet the long-term care needs of older family members.

Several longrun approaches to long-term care reform may also be considered. The National Governor's Association [NGA], for example, recently called for a restructuring of the Medicaid Program. The NGA's national study group on State Medicaid strategies recommends that the Medicaid Program be fundamentally restructured into two systems of care: First, a federally financed and administered National Primary Health Care Program to provide basic health care benefits for all low-income individuals; and second, a State-administered continuing care system, to provide a full range of health and social long-term care services to persons with functional impairments.

An often mentioned, though rarely supported, approach is Medicare coverage for long-term care. It is argued that Medicare should cover the one uninsured risk experienced by an increasing number of older Americans: increased life expectancy and acute disease survival has made long-term care the true risk that threatens the financial independence of older Americans. By the same token, opponents of expanded Medicare coverage need only to cite the cost estimates to stymie serious congressional interest in this proposal.

An alternative approach that has been gaining momentum is long-term care insurance or, as it is called by Senator Heinz, independent living insurance. Several commercial health insurers are investigating the marketability of this idea.

Earlier this year, the Health Insurance Association of America [HIAA] released its report to Congress on private long-term care insurance at a Senate Aging Committee hearing. The HIAA report noted the interest of insurers, but stressed the need to increase public awareness about the risk of incurring long-term costs and to protect insurance companies against losses from a new and relatively untested product. The report also encourages the public sector to work with the insurance industry to assure that products are federally backed and to ensure that the insurance industry does not end up supporting the Medicaid eligible population. Interest in private long-term care insurance seems to be mounting. If significant developments occur in this area it could dramatically alter the long-term care picture in the future.

Part IV

HOUSING

Housing and the shelter needs of the elderly have been a primary concern in the area of aging social policy for a number of years. Heightened concern with old age housing issues had its origins in 1950 when the first National Conference on Aging recommended greater Federal emphasis on the housing needs of older persons. It took almost 10 years, however, for legislation to be enacted that would eventually target the elderly as beneficiaries for such housing assistance.

Although low-income public housing, created under the Housing Act of 1937, was not initially intended to provide special assistance for the elderly, after 1956 it began to evolve into one of the principal forms of Federal assistance for low-income older persons. In 1956, only 10 percent of all the units were occupied by persons 65 years and older. Between 1956 and 1959, however, several legislative changes were made to encourage construction of units for the elderly. As a result, the percentage of public housing units occupied by the elderly increased to 19 percent in 1964 and to 46 percent in 1984. In addition, 1959 saw the enactment of the section 202 program, the first housing program specifically designed for the elderly.

In the mid-1970's, Congress expanded Federal housing assistance to the elderly significantly. The section 202 elderly housing program was reinstated and the section 8 housing assistance program was enacted which, although not specifically targeted to the elderly, has become one of the two major sources of assisted housing units occupied by those 65 years of age and over. Today, section 8 provides approximately 800,000 units of assisted housing for the elderly. Another major source, public housing, provides roughly 650,000 units for elderly families. Section 202, traditionally thought of as the elderly housing program, has just 100,000 apartment units for elderly families.

In recent years, rapidly escalating housing expenses resulting from the general state of the economy and problems with inflation have placed an enormous burden on the many older homeowners and tenants who live on fixed incomes. In addition to increased housing costs, other expenses associated with taxes, utilities, home repairs, and insurance have had a severe impact on older Americans. Dramatic rises in the cost of home energy, for example, have been particularly devastating to the elderly, who consume relatively less energy than other households, but pay a larger portion of their disposable income for fuel. Since 1981, expenditures for home energy among low-income groups have increased, on average, by over 47 percent. The rise in energy costs in relation to income, as well as legislation associated with the crude oil windfall profits tax have has been the impetus behind congressional enactment of several energy assistance programs, designed to help low-income individuals with a special emphasis directed toward the elderly. Since the late 1970's, these assistance programs have grown in both size and scope.

Although the present need for affordable housing and shelter assistance argues for increased Federal efforts and resources, fiscal concerns over the growing budget deficit have made these programs targets for budget savings. The net effect of these fiscal constraints has resulted in a policy shift by the current administration toward other approaches for meeting the housing needs of older persons. Proposals such as housing vouchers, housing and energy block grants, and greater reliance on the private sector for innovative approaches and alternative housing options are advocated. It is expected that housing programs in general, and these new proposals in particular, will be a major focus of the 99th Congress. The following chapters of this report provide a more comprehensive discussion of these issues.

Chapter 9

HOUSING PROGRAMS

OVERVIEW

Combined with food and health care, housing costs comprise the largest expenditures for older persons in today's economy. As the number of older persons as a percentage of the Nation's total population increases, housing programs and the public policy underlying these programs take on added significance. Increasing numbers of frail elderly—those over 75 years of age with mild to moderate impairments in their activities of daily living—are aging in place in Federal housing projects and in private residences. This stark fact raises serious questions on ways to best provide a supportive environment where social, physical, and emotional needs are met without jeopardizing the independence of older Americans.

Today, roughly 2 million low-income elderly renters eligible for Federal housing assistance are currently not served by Federal programs. This problem is expected to continue as the number of older Americans increases and the cost of housing rises in relation to other living expenses.

Current demographic projections indicate that the number of households headed by older persons is rising steadily. More than one-fifth of all U.S. households today—approximately 17 million—are headed by persons 65 years of age or older. Seven million are headed by persons over 75.[1] From 1980 to 1995, the percentage of households headed by persons over 65 will rise by 33 percent, and those headed by persons over 75 will increase 52 percent. In 1995, 21.4 million households will be headed by Americans over 65. The implications of these projections for housing in America, and for Federal housing policy in particular, are enormous.

Rapidly escalating housing expenses have placed a tremendous burden on many older homeowners and tenants who live on fixed incomes. Housing costs are being driven up by taxes, rising utility bills, higher home repair costs, and insurance, as well as rent hikes and condominium conversions. The result is a serious lack of affordable and safe shelter for a large number of older Americans. The problem is particularly acute for renters, who pay a far larger share of their incomes for housing than homeowners. Recent data indicate, for example, that an elderly woman living alone spends nearly 50 percent of her income on housing. Some 2.3 million elderly households spend over 35 percent of their incomes on housing.

It is an often quoted fact that 3 out of every 4 elderly persons own their own homes; 80 percent of them, mortgage free. A majority of these homeowners are graying in our Nation's suburbs. A significant proportion of these elderly suburban homeowners have low incomes, no other significant liquid assets, and need some form of income assistance to maintain themselves. These factors have contributed to the growing interest in innovative housing arrangements, such as home equity conversion plans, and in strategies for allowing the "overhoused" elderly homeowner to take advantage of more appropriate, maintenance-free housing through such alternatives as life-care communities.

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[1] U.S. Bureau of the Census; 1984 Census Population Survey; unpublished data.

Since its inception, housing policy in America has focused almost exclusively on the provision of standard units of low- and moderate-income housing for eligible individuals and families. This approach has been inadequate in two major respects.

First, the Federal Government has been unwilling to treat housing assistance as an entitlement, and, as such, many eligible households simply cannot find the assistance they need. Data indicates that the total of over 4 million assisted units projected to be available by the end of fiscal year 1985 will be enough for, at best, 25 percent of those eligible for assistance.

Second, the primary Federal focus on the brick and mortar aspect of housing fails to address the supportive service needs of those being assisted. Further, this emphasis tends to discourage the development of other shelter alternatives that incorporate such services.

The current administration's program for housing and community development has sought to limit the role of the Federal Government in housing assistance. The main thrusts of the administration's housing assistance policies have been to shrink the growth of the program and to seek less expensive solutions. Since 1981, it has attempted to contain the budgetary growth of housing programs by targeting assistance to those most in need, and relying almost exclusively on direct assistance to households in existing units.

Responding to the administration's policies and concerns over continued high Federal budget deficits, Congress enacted the Housing Act of 1983 [Public Law 98-181]. This legislation eliminated authorizations for the section 8 new construction/substantial rehabilitation program, restricted new construction of public housing to 5,000 units, and limited the authority to build new units to those jurisdictions that could prove that demand and inadequate supply of usable, existing units made new construction the only reasonable alternative.

The section 202 program narrowly escaped a similar fate. Congressional efforts and concerns, however, served to maintain the program at its current level of funding for 14,000 new units annually. Under the act, the section 202 program remained the only housing subsidy authorized to use the section 8 new construction funds.

Other features of the 1983 housing bill reinforced action taken in 1981 to limit eligibility for rental assistance to the neediest families—those at 50 percent of median income—and to raise the rent contributions of those assisted from 25 to 30 percent of adjusted income. In a compromise forced by those opposed to the rent increase, deductions to adjusted income were raised for families with minor children and for the elderly.

Finally, the housing bill of 1983 reaffirmed the administration's interest in the use and rehabilitation of existing housing. It also authorized further experimentation with the administration's housing voucher proposal. The limited voucher program, first enacted in 1983, was to be used in conjunction with multifamily projects assisted under a new rental rehabilitation and production program developed in part to replace the section 8 new construction program. This new two-part program which did not get underway until late 1984, was not expected to provide a major source of housing for low-income elderly Americans. A portion of the 15,000 vouchers authorized for fiscal year 1984 was assigned to a new rural rental rehabilitation program to be administered by the Farmers Home Administration [FmHA] in the U.S. Department of Agriculture.

A. FEDERAL HOUSING PROGRAMS

Beginning in the 1930's with the low-rent public housing program, the Federal role in housing for low- and moderate-income households has expanded significantly. In 1949, Congress adopted a national housing policy calling for a decent home and suitable living environment for every American family. The Federal Government has developed a variety of tools and programs in an effort to achieve this goal. These include direct provision of housing through new construction programs and rental assistance payments which are aimed at providing adequate and affordable housing for those who could not otherwise afford it. The largest assistance, in monetary terms, is that given by tax laws which permit deduction of mortgage interest and property tax payments from gross income in computing a homeowner's income tax.

Approximately 1.5 million units assisted under Federal housing subsidy programs are occupied by elderly households. Recent figures on the numbers of elderly households eligible for assistance, those below 50 percent of median income, indicate that an additional 2 million eligible families are not served by the Federal programs. A substantial number of these families may own their own homes, and although very poor, would not benefit from the subsidy programs designed for low-income renters.

1. ASSISTED HOUSING PROGRAMS

Today, the principal Federal new construction programs benefiting the elderly are the public housing and section 202 programs. The Public Housing Program and the Section 8 New Construction/Substantial Rehabilitation Program repealed in the Housing Act of 1983 were developed to increase the supply of affordable housing for low-income individuals eligible for Federal rental assistance. At the present time, roughly 50 percent of the 2.5 million units constructed through these two programs are occupied by older Americans.

The section 202 direct loan program is designed specifically to construct low-income rental housing for elderly and nonelderly handicapped Americans. But it provides less than 10 percent of the federally assisted units for the elderly. Approximately 155,000 new units are occupied by aged persons.

(A) PUBLIC HOUSING

Conceived during the Great Depression as a means of aiding the ailing construction industry and providing decent, low-rent housing for the families of unemployed blue-collar workers, the Nation's Public Housing Program has burgeoned into a system that includes 1.2 million units housing more than 3.5 million people. In fiscal year 1984, the program cost the Federal Government more that $4 billion for operating subsidies, construction debts, and major repairs.

Much of the public housing was built three and four decades ago and is in need of major renovation. Even its staunchest supporters admit that the program has been plagued by mismanagement in some cities, often aggravated by local political interference and patronage. And, it is a system that has become home to a permanent underclass of chronically unemployed and underemployed people who can ill-afford to pay significantly more in rents to offset the skyrocketing cost of operations and maintenance.

About half of all the units in assisted projects were developed under and continue to operate within the public housing program. It has been by far the largest program for the production of housing for low-income families. In recent years, substantial dissatisfaction with the program has been voiced from several quarters: By Congress about the condition of the projects and their management; by public housing authorities [PHA's] about their rising costs and the inadequate funding levels for modernization; and by the Office of Management and Budget [OMB] about ever-burgeoning outlays. Additionally, the managers of the public housing projects continue to raise their concern about the lack of congregate services for their tenants who have aged-in-place and are in need of supportive services in order to remain independent.

The Low-Rent Public Housing Program is the oldest of those Federal programs providing housing for the elderly. Over 43 percent, approximately 514,000 units, of the Nation's more than 1.2 million public housing units are occupied by older Americans. It is a federally financed program which is operated by locally established, nonprofit PHA's. Each agency usually owns its projects. By law, the PHA's can acquire or lease any real property appropriate for low-income housing. They also are authorized to issue notes and bonds to finance the acquisition, construction, and improvement of projects.

Federal assistance to the public housing projects is in the form of annual contributions that are used to pay the PHA's debt service. Originally this was the only form of Federal public housing assistance. It was assumed that tenant rents, originally set at amounts no higher than 25 percent of a tenant's net income (now raised to 30 percent), would cover project operating costs for such items as management, maintenance, and utilities. Over the past few years, tenant rents have not kept pace with increased operating expenses. Recent changes requiring greater targeting of benefits to the very low income (50 percent of area median rather than 80 percent) also decrease rental revenues for the public housing authorities. As a result, Congress has provided additional assistance to the projects to cover these expenses. Annual operating subsidies totaled $1.3 billion in fiscal year 1984. The Department of Housing and Urban Development—Independent Agencies Appropriation Act of 1985 [Public Law 98-371] appropriated $1 billion for fiscal year 1985.

Other major funding commitments for public housing in fiscal year 1985 are: (1) The authorization of 5,000 units of new construction or acquisition with or without rehabilitation, plus 2,000 units of Indian housing; (2) modernization funds—$1.7 billion is appropriated in fiscal year 1985 for the Comprehensive Improvement and Assistance Program [CIAP], the modernization program.

A large percentage of new construction of public housing over the past 10 years has been for the elderly. The relative lack of management problems and local opposition to family units make elderly projects more popular. Yet, even with this preference for the construction of units for the elderly, in many communities there is a long waiting list for admission to projects serving the elderly. Such lists can be expected to increase as the demand for elderly rental housing continues to increase in many parts of the Nation.

Since 1971, PHA's have had the authority to use Federal funds for the provision of dining facilities and equipment in public housing projects. (No subsidy was to be provided to cover the cost of meals and other services.) To date, there has been little development of these congregate facilities. A study on long-term care released by the Department of Health and Human Services in late 1981 cited a variety of reasons for this, including: Local housing agencies have had little experience in managing the necessary services; there has been little Federal encouragement and support; and there is no assurance of funds to pay for the services on an ongoing basis. Most services have been provided by local services agencies funded by the Older Americans Act, Medicaid, and the Title XX Social Services Act.

Consistent with past trends, the demand for operating subsidies for PHA's will continue to increase. However, in fiscal year 1985, it is anticipated by HUD that stabilization of utility costs and better management will slow the pace of recent increases in the subsidies.

(B) SECTION 202

The section 202 program is the primary Federal financing vehicle for constructing subsidized rental housing for elderly persons. Under the section 202 program, the Federal Government makes direct loans to private, nonprofit sponsors for use in developing section 8 housing designed specifically to meet the needs of the low-income elderly and the handicapped. Since the program's authorization in 1959, over 168,000 units have been constructed.

(1) Background

The original section 202 program operated from 1959 to 1969, when it was phased out in favor of other programs. During this 10-year period, the program provided construction financing and 50-year permanent loans at 3 percent interest to nonprofit and limited dividend sponsors of housing for low- and moderate-income elderly and handicapped persons. Approximately 45,000 units were constructed.

Under the revised section 202 program, authorized in 1974, loans to sponsors were made at a rate based on the average interest rate of all interest-bearing obligations of the United States forming a part of the public debt, plus an amount to cover administrative costs. In 1981, the Treasury borrowing rate began to rise and prospective sponsors feared that financing would become too expensive for them to undertake construction. In 1982, the Senate Committee on Banking, Housing, and Urban Affairs, agreed that HUD should maintain the interest rate of 9¼ percent, and in December of that year, HUD concurred that the 1983 interest rate on these loans would remain at 9¼ percent. The 9¼-percent cap was extended for another year in the fiscal year 1984 HUD appropriations bill.

The original section 202 program was successful. Only one project was foreclosed in a 10-year period. The program served basically middle-income rather than low-income elderly during this time. Since the revised program is used in conjunction with the section 8 program (HUD's major vehicle for the provision of housing to low-income households), it serves a wider income range of elderly households.

Under the revised section 202 program, funds are allocated on a geographic basis for metropolitan and nonmetropolitan areas among the 10 HUD regions, taking into account the number of elderly households within each region, those households lacking some or all plumbing facilities, and those with incomes below regionally adjusted poverty levels. In 1981, there were approximately 4.5 million elderly rental households representing about 30 percent of all elderly headed households in the United States.

The Department of Housing and Urban Development—Independent Agencies Appropriation Act of 1985 (Public Law 98-371) appropriated $600 million of direct loan obligations to be made under the section 202 program. This amount is intended to provide funding for the construction of approximately 12,000 section 202 units, about 2,000 units less than were built in 1984.

Although the section 202 program is often considered a prototype and a key reference point in elderly discussions, there is no up-to-date information base to which Congress can refer when formulating 202 policy. In anticipation of the congressional reauthorization of the program in 1985, the Aging Committee launched a national survey of 202 projects in the fall of 1983.[2] In presenting the results of the survey, the committee warned that the implications of the "graying of America" for housing in America, and for Federal housing policy in particular, are profound. Federal housing policymakers will need to reassess existing programs in light of the values driving most health care and social services policies for the elderly. Although some would argue that the elderly have won more than their share of federally funded housing assistance programs, roughly 2 million of the 3.2 million low-income elderly renters eligible for Federal housing assistance are currently not served by Federal programs. Indeed, the housing needs of several million elderly—housing that is affordable, safe, accessible, and suitable in terms of neighborhood amenities and services—have gone unaddressed.

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[2] U.S. Congress. Senate. Special Committee on Aging. "Section 202 Housing for the Elderly and Handicapped: A National Survey." Committee print, 98th Congress, 2d session. Washington, U.S. Government Printing Office, 1984.

The 202 program is the most visible elderly housing program, even though it is not the largest supplier of housing to older Americans. Policymakers, as well as the public, tend to focus on section 202 as the major elderly housing program, although it represents less than 10 percent of the federally assisted units for the elderly.

While it is not the largest of the Federal housing programs, the section 202 program is the flagship of HUD's production programs. It has had few managment problems, almost no defaults, and there appears to be a high degree of tenant satisfaction with 202 projects as evidenced by low turnover and long waiting lists. Nonetheless, while the politically popular section 202 program has generally produced quality and financially viable housing projects for the elderly and the handicapped, it has also experienced some political controversy. These disputes stem from several problems, including the program's high costs of productions, the tendency, at least of the original program, to serve primarily moderate- and middle-income elderly, and the draw that the program makes annually on the Federal budget because of its use of direct loans from the Federal Government at reduced interest rates. Since 1981, these concerns have led to a halt in the growth in the number of households receiving assistance, a targeting of the available assistance to poorer tenants, and an emphasis on the use of existing stock in place of building new housing projects. By 1983, these policies had the net effect of eliminating all future construction of assisted housing units, except those provided through the section 202 program. Relative to other Federal housing programs, section 202 received small cutbacks. It has been the target of numerous regulatory and administrative changes, however, which are aimed at making the program more cost effective and targeting assistance to the neediest of elderly and handicapped persons.

These recent changes in program direction, as well as those continuing policy issues mentioned earlier, will be the focus of debate during the program's reauthorization in 1985 as well as in the years to come. What follows is a discussion of the findings as they relate to three major policy issues: demand and supply, services, and cost containment.

(a) Demand and supply

Controversy over 202's cost of financing and its allegedly narrow focus have led to attempts by several administrations to end or significantly reduce the section 202 program since its enactment in 1959.

Most recently, in 1983, the Reagan administration requested that the number of section 202 units built be reduced from 14,000 units (already down from 18,000 units in 1981) to 10,000 units.

These efforts to curtail the program fly in the face of what the survey's results demonstrate to be the demand for section 202 units. There are an average of six section 202 units for every 1,000 elderly persons in the country and less than one-fifth of a project's units become vacant annually. As a result, there are over a quarter of a million persons (270,000) waiting to get into the 1,776 section 202 projects nationwide. These figures represent only a fraction of the true number of persons who want the type of shelter section 202 projects provide. Waiting lists represent only those who chose to apply—not those who were discouraged by the prospect of a long wait and therefore chose not to apply.

Survey results confirm the national demand for section 202 assistance. Program cuts have come not only at a time of high demand but also at a time when demand may be increasing. The enormous projected growth of the elderly population suggests the prospect of rapidly increasing shelter and services needs that the Nation has just begun to recognize.

(b) Services

The stated philosophy of section 202 housing is to foster independent living. Section 202 projects were intended to be neither intermediary care facilities nor standard apartment rental units. Instead they were meant to provide shelter plus services which are appropriate to the needs of the elderly and handicapped. Although they were originally designed to serve the well elderly, survey results show that the majority of 202 tenants are aging in place and are now in need of more supportive-type services than when they entered the projects. Survey results reveal that the average age of a tenant living in one of the older 202 projects is 78, while the average age of a tenant living in a project built under the new program is only 71. Results also indicate that, overall, 17 percent of these tenants are considered by project administrators to be frail.

Although an average of six onsite services are offered per project, the types of services (such as personal care and housekeeping) that will enable this aging in place population to remain independent are offered on a very limited and fragmented basis.

For example, there is no section 202 services model that applies to all projects in this program. As a result, project sponsors are free to interpret service needs in whatever way they choose. In the future, Congress will need to develop uniform guidelines to ensure that 202 sponsors will provide supportive services to help their aging populations to remain in their dwellings as they age, rather than to be institutionalized. One promising model, now only available on a limited basis, is the Congregate Housing Services Program [CHSP]. The CHSP originated in the Congregate Housing Services Act of 1978, which authorized HUD to award grants to public housing authorities and section 202 sponsors to provide nutritional meals and supportive services for tenants in their projects. The program was set up as a demonstration program to be evaluated and possibly reauthorized in 1985. At the end of 1983, 62 CHSP projects serving over 2,000 elderly persons were in operation and preliminary, evaluative cost data show the potential for significant savings over institutionalization.[3]

(c) Cost containment measures

Recent changes made to the section 202 program in order to increase the cost effectiveness of the program and allow more units to be built with the same amount of money include requirements that: (1) section 8 recipients in 202 projects pay 30 percent—instead of 25 percent—of the household's adjusted income for rent; (2) at least 25 percent of the units in a project be efficiencies; and (3) sponsors limit the size of the units, congregate space, and number of amenities. Taken together, these new requirements may work to change the program from one providing housing with supportive services for the elderly to one of providing only minimal housing. For example, the establishment of maximum sizes for apartment units and community spaces removes much of the flexibility in design required to meet the changing needs of an aging population. To serve a more frail, elderly population, sponsors need a facility designed with smaller units and more congregate space. Policies of rigidity rather than flexibility may virtually eliminate the possibility of developing a proper facility for an increasingly frail population.

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[3] Anderson, E., report on Congregate Housing Services Program, August 1984.

2. RENTAL ASSISTANCE PROGRAMS

The Reagan administration has enjoyed considerable success in shifting the mix of additional units assisted by HUD from the more expensive new construction and substantial rehabilitation types to existing units leased in the open market. In fiscal years 1982 and 1983, units that were planned to be built but were eliminated from the pipeline outnumbered those for which funds were newly appropriated. Thus, the use of existing units to assist the poor is rising.

The administration's emphasis on using existing housing is based not only on cost considerations but also on the administration's belief that there is an adequate supply of low- and moderate-income rental housing in most areas of the country. The administration has contended that the need for housing assistance in America can be met most efficiently by providing section 8 certificates or, preferably, vouchers to eligible families for use in existing rental housing.

As an alternative to conventional public housing programs, the Reagan administration supports a system under which low-income families would receive vouchers, similar to food stamps for housing, which they could then use to find housing on the private market. The voucher subsidy would be for the difference between 30 percent of the family's income and the fair market rent of a suitable-sized unit. These vouchers are used in conjunction with the New Rental Rehabilitation and Development Program established under the Housing Act of 1983.

(A) SECTION 8

The section 8 program was created in 1974 to provide subsidized housing to households with incomes too low to obtain decent housing in the private market. Under the program, HUD entered into assistance contracts with owners of existing housing or developers of new or substantially rehabilitated housing for a specified number of units to be leased by households meeting Federal eligibility standards. Payments made to owners and developers under assistance contracts were used to make up the difference between what the rental household can afford to pay for rent, and what HUD has determined to be the fair market rent for the dwelling.

As of the end of August 1984, there were 2.2 million units reserved under the program. Of those units, it was estimated by HUD that approximately 40 percent are occupied by older persons.

The concern over the Federal deficit has forced the Federal Government to reassess the cost effectiveness of many social programs, including the new housing construction programs. Neither section 8 nor section 202 was designed originally to provide any form of direct subsidy to project sponsors in meeting their costs of construction and financing. Both were structured to stimulate construction by guaranteeing that low-income occupants would be subsidized through rental assistance programs, thereby assuring occupancy—and rental income—for the developed units.

Shortly after the start of the program, developers found that they had difficulty in keeping their rents below those established by HUD's fair market rents, largely because of the high mortgage rates prevailing in the late 1970's. Consequently, effective rates were lowered for most projects, either by the Government National Mortgage Association's [GNMA] purchase of mortgages under its special function, or by financing from State housing finance agencies or from public housing agencies, both of which obtained funds from sale of tax-exempt bonds. GNMA exhausted its available funds, and it became evident in 1981 that increased rates in the tax-exempt market were threatening to halt assisted housing production. By the end of 1982, limited additional assistance had been provided to projects financed through State housing finance agencies by means of the finance adjustment factors [FAF], which in effect raised permissible rents over the fair market rent level. The relatively high subsidy cost arising from both the high rent supplement required to cover construction costs and the additional indirect subsidy to lower interest rates caused increasing concern in the administration and Congress. Finally, in the Housing Act of 1983, the section 8 new construction program was repealed except for that attached to the section 202 program.

(1) Section 8 Existing Housing

While the production component of the section 8 program has been viewed as unsuccessful, the existing housing component of the section 8 program has generally been alluded to as a successful form of assistance.

The shift from new construction to existing section 8 was made for a number of reasons. For the first time, substantial use could be made of the existing housing stock, with a consequent reduction in per unit subsidy costs from those incurred in new construction. It was hoped that use of the existing stock would provide recipients of aid with a greater choice of location and housing type, since they would not be restricted to specific, designated developments. This was seen as a way not only of increasing household satisfaction but also of promoting racial and income integration, as families could move out of concentrated minority-occupied, low-income areas. The higher income the subsidy provided owners could encourage maintenance of the stock, which otherwise faced deterioration; and improvement of already deteriorated units could be fostered by the rehabilitation program.

Fear was expressed by opponents of this reliance on existing housing that in places with low vacancy rates rents would be driven up for all renters, particularly those of lower income who did not receive a subsidy; that in some places there might be an absolute shortage of standard-quality rental units relative to the number of subsidized households; and that even if there were apparently a sufficient number of units, vacant units might not match the needs of particular types of households, such as large families. As the program has operated, further concern has been expressed that if the acceptable rent is held at a relatively low level, it prevents the dispersion of low-income families out of innercity areas. Even before the section 8 was adopted, HUD had undertaken an Experimental Housing Allowance Program to test the feasibility and advisability of providing a rental subsidy for use in the existing stock. The analysis of this experiment has suggested that rents are generally not increased by the subsidy. Opponents of the shift to exclusive or predominant use of existing housing in subsidy programs, however, maintan that the results are not conclusive, primarily because of the alleged unrepresentative nature of the cities in which the market experiment was conducted.

(2) Tenant Rent Contributions

Prior to fiscal year 1982, families assisted under section 8 were required to contribute not less than 15 percent and not more than 25 percent of their net incomes toward rent. However, the Omnibus Budget Reconciliation Act of 1981 increased the tenant share from not more than 25 percent to not more than 30 percent of net income. For those renters already living in section 8 units, the adjustment was to be made over a 5-year period, with annual percentage increases in rent limited to 10 percent or less. Only new tenants were to be immediately subject to the full effect of the change.

The 1981 act also reduced the income eligibility limit to 50 percent of the median income in the local area from the previous limit of 80 percent, except for 10 percent of those admitted to units available before the act, and 5 percent of those renting units becoming available after the act. It was assumed that this provision would better match low-income housing programs with those who are most in need of assistance. This change was to apply to new tenants only; the continued eligibility of current tenants with incomes above 50 percent of median income was unchallenged. HUD regulations implementing these changes in the law were promulgated in 1984.

(B) VOUCHERS

The Housing Act of 1983 continued section 8 existing certificates but also established a section 8(c) demonstration voucher program. Use of the 15,000 vouchers authorized by the act is limited to HUD's new rental rehabilitation program, the FmHA Rental Preservation Grant Program. The Department of Housing and Urban Development—Independent Agencies Appropriation Act of 1985 [Public Law 98-371] added funding for another 42,000 vouchers.

Under the section 8 existing housing program, HUD pays the difference between 30 percent of an assisted housing tenant's income and the fair market rent standard for the jurisdiction. Under the voucher system, also referred to originally as the modified section 8 existing housing certificate, HUD's contribution will be based on the difference between an established rent payment standard for each market and 30 percent of a new tenant's rent. Like fair market rents, the rent standard will be set at the 45th percentile of the distribution of rents of standard quality in newly occupied units. As with current law, tenant eligibility would be based on an income standard of 50 percent of area median income.

The tenant however, will pay more or less than 30 percent of his income for rent. HUD's contribution would still be based on a 30-percent-of-income contribution. Thus, if a tenant could find a unit which is cheaper than HUD's rent standard, that tenant would be able to keep some of the subsidy for other uses. Conversely, if a tenant rents a unit which is more costly than the rent standard HUD uses, that tenant would have to contribute more than 30 percent of income to make up the rent payment. Another difference between the two programs is the duration of the assistance contract which is limited to 5 years under the voucher program compared to the 15-year duration of the section 8 existing housing contracts. The HUD appropriations act for 1985 provides $500,000 for HUD research budget to evaluate vouchers verses 5- and 15-year section 8 contracts.

Its advocates in the administration argue that the voucher system would avoid the segregation and warehousing of the poor in housing projects and would allow low-income families to choose where they live—all at less cost than a new construction program.

The voucher system has been met with skepticism by Congress and by public housing advocates. In fiscal year 1984, Congress authorized less than 20 percent of the 87,000 vouchers requested by the administration. Critics of the program point to a shortage of decent, low-cost housing in the largest cities and question whether vouchers will provide real help to those most in need or whether they will simply encourage private landlords to increase rents because they know tenants have additional funds available. And since the vouchers are only authorized for 5 years, critics raise the point that they do not represent a long-term commitment to providing housing for the poor.

(C) RENTAL REHABILITATION AND DEVELOPMENT

New rental rehabilitation and production programs were enacted under title I of the Housing and Urban-Rural Recovery Act of 1983, Public Law 98-181. The programs authorize Federal commitments of just 5 years (much shorter than the 15- or 20-year commitments under section 8), greater requirements for local public and private sector investments in the projects, stricter limits on Federal per unit costs, and greater demonstration of rental housing need by local authorities. Interim regulations governing the rehabilitation portion of the program were issued on April 20, 1984, while regulations governing the production segment of the program were published on June 14, 1984.

The $300 million rental rehabilitation program is formula driven and allocates funds directly to selected cities with populations of

50,000 or more, urban counties, and States for distribution to smaller communities. The program is targeted to low- and moderate-income families. The first grants under the program, which totaled $14.2 million, were awarded to 76 cities and urban counties and 1 State in August 1984. These grants should assist in the rehabilitation of 2,840 units. In addition, grantee communities will get about 2,840 housing vouchers or section 8 certificates to assist lower income families to remain in their unit after rehabilitation activities are completed or to relocate to other suitable housing.

The $315 million Rental Housing Development Program will be run on a competitive basis and will be targeted toward low- and moderate-income families as rental rehabilitation grants. Implementation of this program was delayed by the controversy over the size and composition of cities eligible to compete for grants. On June 20, HUD published in the Federal Register a list of areas designated as eligible for program assistance. On October 23, 1984, HUD announced the awarding of $288 million to 141 projects. It is estimated that these awards will assist in the construction of 14,462 units. These awards leave just $27 million available for additional awards for the remainder of the 1985 fiscal year.

A total of $615 million was authorized in the Housing and Urban-Rural Recovery Act of 1983 for these two programs for fiscal years 1984 and 1985. These are very modest programs, compared to the costs of section 8 new construction/substantial rehabilitation programs which they are designed to replace. The latter, for instance, were allocated more than $10 billion in new budget authority in fiscal year 1981.

B. HOUSING RELATED TAX PROVISIONS

The principal tax provisions promoting homeownership and the production of housing in this country include: Homeownership tax subsidies, rental housing investment subsidies, and tax-exempt mortgage revenue bonds. Of principal interest to elderly Americans are: The one-time exemption from taxes of up to $125,000 in capital gains for those over 55; and the multifamily rental production incentives provided in the Tax Code and through mortgage revenue bonds.

Given current high interest rates, there would be very little construction of multifamily rental housing without tax provisions such as accelerated depreciation; amortization of construction-period property tax and interest expenses; low-income rental housing rehabilitation and historic preservation tax credits; and the sale of tax-exempt bonds. Even so, these incentives tend to lead to the production of housing for renters in the moderate and upper income brackets, rather than for the poor. Low-income projects are more risky, are less profitable, and attract fewer investors. For this reason, tax-exempt bonds for multifamily mortgages have been statutorily limited to projects with at least 20 percent of their units occupied by low-income renters. For similar reasons, several of these rental housing investment tax subsidies and the Mortgage Revenue Bond Program have come under increasing attack from Treasury officials and Members of Congress concerned about untargeted Federal tax expenditure programs.

The tax-exempt bond program has led to the establishment of State housing finance agencies, some of which are engaging in innovative housing programs for the elderly. There are also many State and local tax provisions which serve as incentives for housing and rehabilitation and rental housing investment.

The Deficit Reduction Act of 1984 [DEFRA] contained a provision to reinstate section 190 of the IRS Code which allowed a special tax deduction for up to $25,000 of expenses incurred during a taxable year in removing architectural or transportation barriers to the handicapped and the elderly. This provision was effective for taxable years beginning before 1983.

Section 190 applies to expenses incurred to make facilities or public transportation vehicles that are owned or leased by the taxpayer for use in the taxpayer's trade or business more accessible to, and usable by, the handicapped and elderly. To be entitled to the deduction, the taxpayer must establish that the barrier removal meet standards set by the Treasury with the concurrence of the Architectural and Transportation Barriers Compliance Board. Under section 190, the definition of an elderly person is a person age 65 or over, and handicapped individuals include the blind and deaf. In addition to having the section reinstated, DEFRA raised the maximum deduction allowed to $35,000.

C. INNOVATIVE HOUSING ARRANGEMENTS

The single-family house, once the symbol of a growing country, now marks the graying of suburbia. Increasingly empty of children, it has come to represent the discrepancy between the needs of a burgeoning population of elderly homeowners and the lack of housing alternatives. Recently, several types of solutions to the problems of those elderly marooned in houses too large for their needs and too costly to maintain have surfaced. These include: Home equity conversion plans; shared housing and ECHO, or granny flat arrangements. In addition to these private sector initiatives, Congress in 1978 enacted the Congregate Housing Service Demonstration Program [CHSP]. It authorized the Department of Housing and Urban Development [HUD] to award grants to public housing authorities and the nonprofit sponsors of section 202 projects to provide meals and supportive services to partially impaired elderly and handicapped persons. The objective of the congregate program, which now has 64 projects serving more than 2,700 elderly, is to enable the frail elderly to remain in their own dwellings and to avoid unnecessary institutionalization.

1. Home Equity Conversion Plans

A great deal of attention has been given in recent years to financial arrangements which would permit aged homeowners to convert part of their equity into cash, without having to leave their dwellings. These home equity conversion plans [HECP's] offer a choice to elderly persons facing necessity-heavy budgets that have grown proportionately faster than their incomes. They could also provide funds to allow older persons to pay for needed support services, home maintenance, and other needs. Before HECP's, the only source of equity borrowing available to older Americans was through the traditional financial institutions at high rates and short terms.

(A) ISSUES AND OPTIONS

Homes of older Americans are their most commonly held and most valuable asset. Recent statistics indicate that of the three out of every four elderly persons who own their own homes, 80 percent do not have a mortgage. The total value of the equity held by older Americans is over $600 billion. Equally as significant, a large proportion of older homeowners are likely to have relatively low incomes. For example, 6 out of every 10 elderly single homeowners have incomes of $5,000 or less.

There are two distinct types of conversion plans—debt and equity—that a variety of models are based on. Debt plans allow an older homeowner to borrow against home equity with no repayment of principal or interest due until the end of a specified term of years, or until the borrower sells the home or dies. These plans can provide a single lump-sum payout to the borrower, a stream of monthly payouts for a given term or—with the addition of a deferred life annuity—guaranteed monthly payouts for life. They are often referred to as reverse mortgages or reverse annuity mortgages [RAM's].

Property tax deferral programs, popular in many States, are a form of debt plan in which older homeowners postpone paying their taxes until they sell their homes or die. In State-initiated deferral programs, the State pays taxes to the local government for the homeowner. These payments accrue with interest as a loan from the State to the homeowner, secured by equity in the home. Upon death or prior sale of the home, the total loan is repaid to the State from the proceeds of the sale or the estate.

Equity plans involve sale of the home to an investor, who immediately leases it back to the seller. Land contract payments of the seller exceed term payments to the buyer, so the older person receives extra cash each month. In addition, the buyer pays for taxes, insurance, and maintenance. A deferred annuity or other investment purchased with the downpayment can provide income beyond the land contract term. These plans are also referred to as sale/leasebacks.

The basic theoretical forms of HECP's have been developed for several years. In general, however, workable instruments have yet to become widely available to the public. One reason for the lack of substantial interest is that the combination of financial benefits and risks associated with the plans has not been sufficiently attractive to borrowers.

Volatile interest rates have made plan development even more difficult. Yet progress has been made. Two pilot programs launched in 1981 were operating successfully in 1984. The San Francisco Development Fund's Reverse Annuity Mortgage Program is a comprehensive system for delivering reverse mortgages and sale/leasebacks to older homeowners. Buffalo's Home Equity Living Plan [HELP] Inc., offers elderly homeowners immediate property rehabilitation as needed, a lifetime maintenance contract, payment of property taxes for life, and a monthly cash payment for life. In exchange, the homeowner agrees to relinquish title at death.

Additionally, three new home equity conversion programs got their start in 1984. These are the Grannie Mae, the Century Plan, and the Older Americans Consumer Cooperative.

Family Backed Mortgage Association, Inc., of Oakland, CA, has formed a division called Golden Retirement Mortgage Association or Grannie Mae. Under Grannie Mae, the home of an elderly person is sold to one or more of the children, other relatives, or outside investors with a fixed-rate, 15-year mortgage provided by Grannie Mae or a financial institution. The seller receives a lifetime annuity from the sales proceeds and a life tenancy of the home at a fair market rent. As of June 1984, lenders associated with Grannie Mae included First National Savings of San Francisco (which will make loans in California, New York, and Florida), First National Bank of Chicago, Dominion Federal Savings & Loan in the Washington, DC, area, and City Federal Mortgage in New Jersey and 22 other States. The annuities will be handled by Occidental Life Insurance Co. As of October 1984, however, Grannie Mae had not closed any transaction, though the plan has generated considerable interest.

In the beginning of 1984, a new home equity conversion plan model emerged from a private corporation, American Homestead, Inc. [AHI], a licensed mortgage bank in New Jersey. The Century Plan is the first long-term reverse mortgage. The plan has been designed to attract the interest of the private financial market. Under the plan, older homeowners would receive monthly checks ranging from $100 to $500 as an income supplement until the homeowners asked to have them stopped or until the owners move, sell their property, or die. When the payments end, the homeowners or their heirs would owe the dollar amount of the monthly checks; deferred interest computed at a fixed rate slightly below what was prevailing in the mortgage market at the time the original payment contract was signed; and a percentage of the increase in the resale value of the house since the date of original contract. All loans to property owners would be secured by first mortgages against their homes.

By pooling the mortgages into packages of 1,000 loans apiece, American Homestead hopes to cut the financial risks of excess payments to borrowers whose property values don't go up as expected, or who live longer than the average person in their age bracket. To further reduce risks, the amount of the monthly payment would be tied to the age and sex of the homeowner, the amount of existing equity in the dwelling, and the amount of future appreciation the owner contracts to share.

In August 1984, Prudential-Bache Mortgage Services began offering the Century Plan in New Jersey and the five Pennsylvania counties of metropolitan Philadelphia. Prudential-Bache markets the plan under a new account called the Individual Retirement Mortgage Account. If this test marketing proves successful the plan will be offered in other parts of the country in 1985.

The Older Americans Consumer Cooperative [OACC] is a self-help consumer health care organization. Membership is open to all people who are over the age of 60 or who are Medicare beneficiaries. The mission of OACC is to enable and empower members to gain better access to improved and more affordable medical and social care. OACC is also committed to increasing the ability of members to live with maximum health, independence and dignity at home. OACC will work with local banks to enable members to borrow money at a fair rate of interest by using a portion of the equity in their homes as collateral. This service is designed to provide members with an alternative to paying out-of-pocket, giving up their home or foregoing needed care.

In August 1984, the Social Security Administration issued its first formal communication on how the proceeds of home equity conversion plans will be treated in determining eligibility and benefit levels for supplemental security income. This document (SSA Pub. No. 17-004, SSA Program Circular 09-84-OSSI) describes various types of home equity conversion plans and indicates the specific program operations manual system instructional references that govern how the proceeds of the different plans are to be treated.

(1) FHA Demonstration Program

A reverse mortgage insurance plan was proposed by the Department of Housing and Urban Development in 1983. The insurance plan had three basic purposes: First, to meet the special needs of elderly homeowners by insuring the conversion of home equity into liquid assets; second, to encourage and increase the involvement of lenders and secondary market participants; and third to permit evaluation of data regarding demand, supply, and appropriate Federal participation. The proposed demonstrations authority provided for insurance coverage for up to 1,000 reverse mortgages through September 1986.

House-Senate negotiations on the HUD proposal led instead to language requiring HUD to evaluate existing reverse mortgage programs. The evaluation was to be submitted to Congress at the end of 1984, however HUD had still not reported its findings as the year drew to a close.

(2) Sale Leaseback Bill

A bill to clarify Federal tax treatment of residential sale/leaseback transactions [S. 1914] was deleted during House-Senate negotiations on the 1984 tax legislation bill. The bill, introduced by Senator Specter, would have created a safe harbor for sale/leaseback transactions so that the tax treatment would be the same as that of conventional home sales and rentals. Such legislation is needed due to current uncertainty about the tax treatment of sale/leasebacks, which has discouraged older homeowners from utilizing this form of home equity conversion.

The final version of the legislation was substantially different from the original version of S. 1914 due to add-ons to the bill during review by the Senate Finance Committee. These additions resulted from concern by both the Finance Committee staff and the Treasury Department that increased used of sale/leasebacks involving the elderly might lead to annual tax revenue losses of up to $100 million. These estimates were challenged by the bill's supporters.

The additions would actually change existing law by excluding from the safe harbor any sale/leasebacks involving family members and investor groups, and requiring 40-year depreciation rather than the 20 years allowed under existing law. These restrictions completely undermined the intent of the original legislation and would discourage even those sale/leasebacks which are legal and feasible under current law. The exclusion of family members would make sale/leasebacks unattractive to those who are most competent and most likely to be trusted by the elderly homeowner; the 40-year depreciation requirement makes sale/leasebacks uneconomical for even those included in the safe harbor. The impact of these provisions held potentially disasterous consequences for elderly homeowners. Current activity and interest in sale/leasebacks would have been virtually halted. Many older homeowners would then have no other alternative than to remain in their homes with insufficient income, or sell and give up their homes.

Because of concerns by both House and Senate members of the tax conference committee about the potentially disastrous impact of these new provisions, the bill was deleted. The Treasury Department will conduct a study during 1985 on: (1) What the economic life of potential sale/leaseback level properties are; and (2) what depreciation level is necessary to make sale/leaseback transactions viable.

2. Shared Housing

Shared housing can be best defined as facilities housing at least two unrelated persons where at least one is over 60 years of age, and in which common living spaces are shared. It is a concept which targets single and multifamily homes and adapts them for elderly housing. Shared housing can be agency-sponsored where usually 4 to 10 persons are housed in a dwelling, or it may be a private home/shared housing situation in which there are usually three or four residents.

The economic and social benefits of shared housing have been recognized by many housing analysts. Perhaps the most easily recognized benefit is that a companionship for the elderly. Also, shared housing is a means of keeping the elderly in their own homes, while helping to provide them with the means to maintain these homes. In some instances, elderly who otherwise would be overhoused can help families who may be having difficulties in finding adequate housing arrangements.

From an economic viewpoint, shared housing can be an important low-cost means of revitalizing neighborhoods. Abandoned large houses and buildings could be made suitable for shared housing with very little renovation. Dennis Day Lower, director of the Shared Housing Resource Center in Philadelphia, has pointed out that shared housing is extremely cost effective when compared to new construction. He has noted that per unit capital costs could be as much as 50- to 60-percent lower using shared housing.

There are various impediments to shared housing. Among the most prominent are zoning laws and reduced supplemental security income and food stamp payments to participants. Congress recognized the need to overcome these impediments, and has begun to act by including a provision in the Housing Act of 1983 for section 8 rental assistance to be used with shared housing. Under this provision, the existing and moderate rehabilitation program of section 8 can be used to aid elderly families in shared housing. HUD will issue minimum habitability standards to insure decent, safe, and sanitary housing conditions for such dwellings. The Housing Act of 1983 also included shared housing as an eligible activity under the Community Development Block Grant Program.

Several shared housing projects are in existence today. Anyone seeking information in establishing such a project or looking for housing in a project can contact two knowledgeable support services. One is Operation Match, which is a growing service now available in numerous communities throughout the country. It is a free public service open to anyone 18 years of age with no sex, racial, or income requirements. Operation Match is a division in the housing offices of many cities, and helps match people who are looking for an affordable place to live with those who have space in their homes and are looking for someone to aid them with their housing expenses. Some of the people helped by Operation Match are single, working parents with children, those in need of short-term housing, elderly people hurt by inflation or health problems, and the handicapped who require live-in help to remain in their homes.

The other source of information in shared housing is the Shared Housing Resource Center in Philadelphia. It was founded in 1981, and acts as a linkage between individuals, groups, churches, and service agencies that are planning shared households.

3. ACCESSORY APARTMENTS AND GRANNY FLATS

Accessory apartments have been accepted in communities across the Nation. These apartments were occupied by members of the homeowner's family, and, therefore, accepted into the neighborhood. Now, with affordable rental housing becoming more difficult to find, various interest groups, including the low-income elderly, are taking a closer look at this type of housing.

Basically, accessory apartments are another form of shared housing, except that each unit has its own kitchen. Thus, this form of housing undergoes the same zoning restrictions and impediments already discussed in the section of this report concerning shared housing. A few jurisdictions have modified local zoning rules to permit accessory housing, primarily in California.

Another innovative housing arrangement under discussion is the "granny flat" or "ECHO flat," first constructed in Australia and recently introduced in this country. "Granny flats" were constructed as a means of providing housing for elderly parents or grandparents where they can be near their families while maintaining a measure of independence for both parties. In the United States, we refer to such living arrangements as "ECHO units," acronym for elder cottage housing opportunity units. ECHO units are small, freestanding, barrier free, energy efficient, and removable housing units that are installed adjacent to existing single-family houses. Usually they are installed on the property of adult children, but can also be used to form elderly housing cluster arrangements on small tracts of land. They can be leased by nonprofit corporations or local housing authorities.

Rigid zoning laws, lack of public information, and concern about adverse changes to the neighborhood, and therefore, property values, are the major barriers to the development of ECHO housing. Many civic leaders, public officials, and organizations are reporting increased interest in the possibility of ECHO units for their jurisdictions. At this time, there is no Federal legislation dealing with this concept.

4. Congregate Housing Services

The Congregate Housing Services Act of 1978 authorized HUD to award grants to public housing authorities and section 202 housing sponsors to provide nutritional meals and supportive services for tenants in their projects. The program was set up to be a demonstration program, with $20 million appropriated to be spent over a 5-year period, after which HUD is to give an evaluation and report to Congress. The program's chief function is to help the elderly remain in the rented dwellings as they age, rather than to be institutionalized. Since 1979, $24 million has been distributed to the 64 CHSP projects serving over 2,700 elderly persons nationwide. Preliminary evaluation of the CHSP indicates it may be serving those individuals most in need and may be cost effective compared to more formal institutionalization. (See section 202 executive summary for details.)

During debate on the HUD-independent agencies appropriations bill for fiscal year 1985, Senators Heinz, Glenn, and others were successful in adding an amendment for $4.1 million to fund the 29 CHSP contracts due to expire during 1985. The funds will allow these CHSP contracts to continue pending HUD's evaluation of the program due to be sent to Congress in early 1985. The demand for this and similarly designed programs that coordinate housing and supportive health care and housekeeping services in assisted housing as well as private homes is sure to increase enormously. In spite of this anticipated increase in demand, the concern over large Federal deficits makes any major new Federal initiatives in this area unlikely in the foreseeable future.

D. RETIREMENT COMMUNITIES AND OTHER LIMITED CARE FACILITIES

Although the Federal Government is supporting several congregate care housing demonstration projects and a few States are establishing congregate housing programs, there is little direct public assistance to fill the gap between totally independent living arrangements and health-care-oriented retirement communities. Accordingly, the private sector has stepped in to provide various options ranging from low-cost elderly housing and board and care facilities to relatively expensive life care communities and retirement communities.

In the past, the Senate Special Committee on Aging has made a point of scrutinizing the Nation's estimated 300,000 board and care homes serving low-income older persons. The Aging Committee, in 1983, also conducted an investigative hearing on the benefits and shortcomings of the life care industry. One of the committee's major objectives in 1985 will be to learn more about the demand for and the conditions in the generally subsidized, and loosely regulated area of semi-independent living for the elderly.

1. BOARD AND CARE HOMES

The more than 1 million residents of boarding homes, and foster, adult, or domiciliary care facilities are usually receiving some form of public assistance. Managers of the 300,000 such homes have often been criticized for inadequate safety and security measures, poor care, abuse of the residents, and even financial fraud.

It was not until 1976 that public concern finally led Congress to require State licensing and regulation of these facilities. The Federal law, however, has had limited impact on the boarding home industry. In order to strengthen protections for residents in board and care homes, the Federal Government may consider the provision of minimal levels of medical care and other supervision in addition to room and board, as well as enforcement of fire and safety standards and other building design changes for physically impaired residents.

2. RETIREMENT COMMUNITIES AND LIFE CARE COMMUNITIES

Life care is the concept whereby an individual, through a contractural arrangement with a life care facility, agrees to pay an entrance endowment fee ranging from $20,000 to $100,000 and a monthly service fee in return for the lifetime use of a living unit, the guarantee of specified health and, generally lifetime nursing care as needed, and a variety of other services and amenities. In a broader sense, life care communities provide a kind of combined health, housing, and social care insurance.

Middle income and more affluent older Americans often choose to live in retirement communities including life care communities rather than maintaining their own homes. These multilevel care facilities generally offer meals, social support services, and access to health care to elderly persons living in independent housing units. Sponsored by churches, labor unions, other nonprofit groups, private companies, and individuals, these communities vary from a single building to campus like settings. Concerns about the problems of home maintenance, loneliness, and future health care motivates older Americans to seek the social and other benefits that these facilities provide.

Reliable data on the size of the life care industry is scarce. Nevertheless, depending upon definitions used, most observers agree that it is an extensive and growing industry with at least 300 to 600 facilities presently in existence, housing an estimated 100,000 residents. In 1984, revenues for such facilities are projected to reach approximately $1 billion.

A study released in 1984 by the Wharton School at the University of Pennsylvania found:

—The average age of life care communities' residents is age 80.

—Twenty percent of all life care communities were found prior to 1960, 40 percent were constructed since 1970.

—With the exception of New York, which prohibits life care arrangements, the distribution of life care communities throughout the United States follows the distribution of aged individuals. Over two-thirds of all life care communities are located in the following States—listed in rank order by number of facilities: California, Florida, Pennsylvania, Ohio, and Illinois.

—Contrary to the belief that once an individual enters a life care community health care services are a free good, the basic principle of co-pay is widely used.

The types of problems that have been encountered in some life care facilities relate to financial management and proper representation of the services and the benefits that are to be provided:

—Some life care communities function using lifespan and health projections that are not actuarially sound and future revenues and cost projections that are incorrect.

—Some contracts are written in such a way that if a person decides, even within a reasonable period of time, that he or she does not want to stay at the facility, the entire endowment is lost and not returned even on a prorated basis.

—Recently, there has been a growth of private, nonprofit corporations which sponsor life care facilities. While the individual facility is clearly nonprofit, the corporation that organizes and develops the project is often a for-profit organization. The profitmaking goals of the developer may conflict with the financial stability of the nonprofit corporation; for example, in order to attract consumers and quickly raise funds, the pricing structure may be established too low to provide both profit and future financial stability.

The Senate Special Committee on Aging, on May 25, 1983, conducted a hearing, entitled, "Life Care Communities: Promises and Problems," which marked the first time a congressional committee had addressed this fast growing and significant housing, service, and health care option for the elderly. The Aging Committee received testimony from residents of two life care communities, from a team of nationally recognized experts who advocated the increased development of life care, and from representatives of State and Federal law enforcement and regulatory agencies that have had experience with some of the unique problems associated with this industry.

(A) RECENT TAX CHANGES

Tax legislation enacted in the 98th Congress includes a provision that may affect life care residents, and thus the life care industry. The law could increase the residents' cost to live in life care communities, and thus, discourage prospective residents from moving to this type of community. As a result, existing life care residents may find themselves in a retirement facility that becomes financially insolvent.

Congress, in passing the below-market interest rate provisions of the new tax law, attempted to protect residents living in continuing care communities before June 7, 1984, by exempting them from the new law. However, this exemption may not protect current residents since it only addresses personal tax liability and failed to take into account the fact that existing facilities may be unable to attract replacement residents.

While most people feel that the new tax law applies to life care facilities, regulations have not been issued as yet. The law, the Deficit Reduction Act of 1984, section 172, added to the Internal Revenue Code, section 7872 to recharacterize interest-free loans as interest bearing loans. Under the act, entrance fees paid by residents of life care communities after June 5, 1984, may be treated as an interest free loan. The lender (in this case the elderly resident) will be required to recognize a statutory rate of interest income (10 percent until the end of 1984 and 12.37 to 14.43 percent in the first 6 months of 1985), and pay a tax on this income. The borrower (in this case, the life care community) is deemed to have a deduction equal to the amount of interest, which the lender is deemed to have received.

There are many types of transactions that the interest free loan provisions are designed to reach. Congress intended for the legislation to reduce the tax avoidance aspects of interest-free loans, that is, interest-free loans by higher income taxpayers to individuals in a lower tax bracket. When life care residents transfer the use of the principal (entrance fee), they decrease the cost of their residing in the community by, in effect, decreasing their taxable incomes. While the legislation does not specifically cite entrance fees to life care communities, it could apply to this type of transaction.

Because the legislation could have the effect of increasing the cost to reside in a life care community, Chairman John Heinz and other members of the Aging Committee were concerned that hardships may occur for existing residents. Prospective residents could be discouraged from moving into life care communities, which could jeopardize the communities' financial solvency. If a community goes bankrupt, existing residents will lose their entrance fees, which is their investment in lifetime housing and health care benefits. For most residents, the entrance fee represents a major part of their assets.

Senator Heinz, along with other Members of the Senate, asked the Acting Assistant Treasury Secretary for Tax Policy to exempt in the Treasury Department's definition of interest-free loans, refundable or partially refundable fees paid by life care residents. They also asked the Acting Secretary to take into consideration the size of the loan and offsetting deductions for specified imputed payments such as medical expense deductions. Senator Heinz's letter stated:

> For the majority of the Nation's 600 continuing care facilities, entry fees are clearly not loans, but payments that provide reserves sufficient to guarantee that lodging and medical and nursing care will be made available to residents during the remainder of their lives.

The letter called on IRS to "immediately" issue interim or transition rules "which exempt continuing retirement care facilities" from the interest-free loan provisions.

Additionally, in October 1984, during Senate floor debate on the imputed interest issue, Aging Committee members Senators Heinz and Chiles and Senate Finance Committee Chairman Dole engaged in a discussion of the possible problems CCRC's could encounter because of this new provision. This exchange of views outlined agreement on several important aspects of the issue. Among other things, the agreement accomplished the following:

—Moves the effective date at which residents in existing facilities could be subject to the new tax regulations, with consent of Treasury, from June 6, 1984, to the date of issuance of the regulations.

—Establishes that in the case of a fee which is only partially refundable or not refundable at all after a period of time, it will not be considered to be a loan for the periods which or with respect to amounts which are not refundable.

—Provides direction to Treasury that may preclude the Department from automatically characterizing CCRC entry fees as loans subject to taxation in regulations.

—Sets a meeting between Treasury, the three represented Senate staffs and representatives of the continuing care industry, to be held prior to the issuance of regulations.

—Requests an evaluation from Treasury of the merits of the argument that a broad exemption is needed to adequately protect existing residents from the effects of cost increases for new residents; and

—Schedules a Senate hearing for soon after the newly elected 99th Congress convenes, to specifically address the problems CCRC's could encounter resulting from possible taxation.

(B) STATE REGULATORY ACTION

Being a relatively new and growing phenomenon, life care is just beginning to be understood and regulated. California, in 1969, was the first State to regulate life care. Today, only 12 States regulate the operation of life care communities. These States are: Arizona, California, Colorado, Florida, Illinois, Indiana, Maryland, Michigan, Minnesota, Missouri, Oregon, and Pennsylvania. New York, which bans prepaid nursing home care, effectively prohibits life care arrangements. There is little uniformity in the way these facilities are regulated by the States. Some States require operators to make public ownership and financial disclosures, others do not. Similarly, some States regulate resident rights and others do not. Few if any of the States offer adequate protection from the operator who deliberately seeks to use complex profit/nonprofit business structures and non-arms-length transactions to enhance his personal wealth at the expense of the life care residents.

The Wharton School study suggested that States, when regulating life care, should address issues such as: Facility certification and accreditation; management of escrow accounts, maintenance of reserve funds, required financial disclosures, strengthening preconstruction disclosure requirements for bond holders; and the development of methodologies to be used to test the ongoing financial viability of the community.

While certain Federal agencies such as the FTC, SEC, HHS, HUD, and FBI have from time to time been involved in limited aspects of life care, there is no significant, direct Federal involvement in this industry at this time. It is clear that if any comprehensive

Federal response is to be developed, it will need to come from some congressional initiative. Bills that address the life care phenomenon have been introduced since the 95th Congress. More are expected as the 99th Congress convenes.

Life care can become increasingly significant for growing numbers of people and for the society as a whole. But just as clearly, potential residents need to understand the nature of the financial risks involved and each facility must be soundly based and operated under adequate financial planning. Otherwise, the promise of life care can become illusory and the loss to residents catastrophic.

E. CONCLUSION

Federal housing policymakers must now make a serious examination of the broader shelter needs of America's aged and of policy options for addressing them. The commonly held goal to enable the elderly to remain in their homes as long as possible must be explored with diligence as the elderly population continues to grow. A corollary is that the frail elderly should be cared for in the least restrictive environment, both for the quality of life considerations and for cost effectiveness. Increasing numbers of older persons are in need of in-home assistance or supportive living environments. Accommodating these needs will require greater cooperation between Federal housing, health, and human services agencies as well as the private sector to promote the expansion of a wide variety of shelter services.

In effect, the Federal Government needs to find ways to implement the principles of the congregate housing program for all persons in need, rather than just those few federally assisted housing projects. The demand for programs that coordinate housing, health care, and other supportive services will increase enormously in the next several decades.

Several of these forthcoming issues were addressed at a Senate Special Committee on Aging hearing on April 23, 1984, entitled "Sheltering America's Aged: Options For Housing and Services," which examined the problems as well as the opportunities in providing appropriate shelter and services, especially for the low-income frail elderly. Chairman Heinz received testimony from three panels of expert witnesses. The first panel examined public sector programs, and innovations such as the Massachusetts State Congregate Housing Program which has proven to be a cost-effective, quality program in delivering appropriate care to the State's frail elderly population.

Under Secretary for Housing Philip Abrams testified on the Federal efforts toward providing shelter, acknowledged the importance of the section 202 program and gave a positive preliminary report on the Federal Government's CHSP Program. The second panel of witnesses spoke to the needs of the frail elderly and the aging in place as a phenomenon for Federal concern. The third panel of experts reviewed a range of shelter options available presently on a fragmented basis such as shared housing and accessory apartments and the need to promote these underutilized options on a national basis. Witnesses also discussed the potential that home equity conversion has for providing independent living insurance to the over

2 million elderly homeowners at risk of institutionalization. The estimated $70 billion in assets owned by these homeowners could generate an average of $3,000 per year per individual of home health care or long-term care insurance.

As Congress reauthorizes the major Federal housing assistance programs for older Americans in 1985, additional ways of enhancing the current law's responsiveness to the housing and services needs of the elderly, especially the low-income frail elderly will need to be examined.

Chapter 10

ENERGY ASSISTANCE AND WEATHERIZATION

OVERVIEW

In the 11 years since the OPEC nations instituted the full scale embargo on oil sales to the United States, energy use and conservation have become major domestic policy issues.

The radical changes in world oil markets following the 1973 embargo brought equally radical changes in household budgets of Americans. The proportion of income required to purchase essential energy supplies rose dramatically, and changes in the cost of this basic commodity brought changes in the cost of many other necessary items. Although these changes had different impacts depending on a household's income and fuel requirements, during the past 11 years the pressure for change in consumption patterns and the erosion of real spending power due to energy inflation has been unrelenting. The rising cost of energy has had a particular effect on the elderly and those with low incomes, who consume relatively less energy than other households, but pay a larger portion of their disposal income for fuel.

In an effort to ease this burden for needy individuals, a number of Federal programs have been implemented to provide energy relief. The most significant of these are the Low-Income Energy Assistance Program [LIEAP] and the Department of Energy's Weatherization Program. Over the years, both programs have undergone repeated modifications in response to both growing need and apparent deficiencies in their design and implementation.

During 1984, both the LIEAP and DOE weatherization programs were authorized by the Omnibus Budget Reconciliation Act of 1981. Under the LIEAP Program, the Secretary of Health and Human Service [HHS] provides grants to States for the purpose of making financial assistance available to low-income households with home energy costs that are excessive in relation to household incomes. Funds are provided in the form of direct cash assistance, direct payment to fuel vendors or utility companies, or payments to public housing building operators. The Weatherization Assistance Program, on the other hand, is designed to respond to the current incentives for conservation. The program provides grants to States to improve the energy efficiency of the homes of low income individuals.

In the 1984 budget request, the Reagan administration proposed to replace LIEAP with a block grant to States, and requested no funding for the Weatherization Program. It also proposed to dismantle the Department of Energy. Although Congress studied numerous energy assistance proposals, it rejected the administration's approach, and decided to continue the program essentially the same as they operated during fiscal year 1983.

Under the Omnibus Budget Reconciliation Act of 1981, the LIEAP Program expired on September 30, 1984. The President's fiscal year 1985 budget recommended that Congress reauthorize LIEAP through fiscal year 1989 with an annual authorization of $1.875 billion, which was equal to the fiscal year 1984 authorization, but $200 million below the final 1984 appropriation. In addition, the administration proposed funding the program from a petroleum overcharge restitution fund [PORF] as opposed to general revenues. The PROF was expected to result from settlements collected by the Federal Government through litigation against oil companies involved in price gouging in the early seventies. The Senate and House of Representatives again rejected the administration's proposal, and instead, reauthorized the LIEAP Program as part of an omnibus human services reauthorization bill [S. 2565] that was passed in the last weeks of the 98th Congress.

During 1984 the Weatherization Program was funded under the Interior Appropriations Act [Public Law 98-146] at a level of $190 million. In its fiscal year 1985 budget request, the administration proposed continuation of the Weatherization Program at the 1984 funding level. Like the LIEAP Program, the administration recommended that weatherization activities also be funded from the petroleum overcharge restitution fund. In spite of considerable debate on this issue, Congress failed to act on this proposal. In conjunction with the reauthorization of the LIEAP Program, Congress also made a series of improvements to the Weatherization Program in the Human Services Reauthorization Act of 1984 [S. 2565].

A. ENERGY ASSISTANCE ISSUES

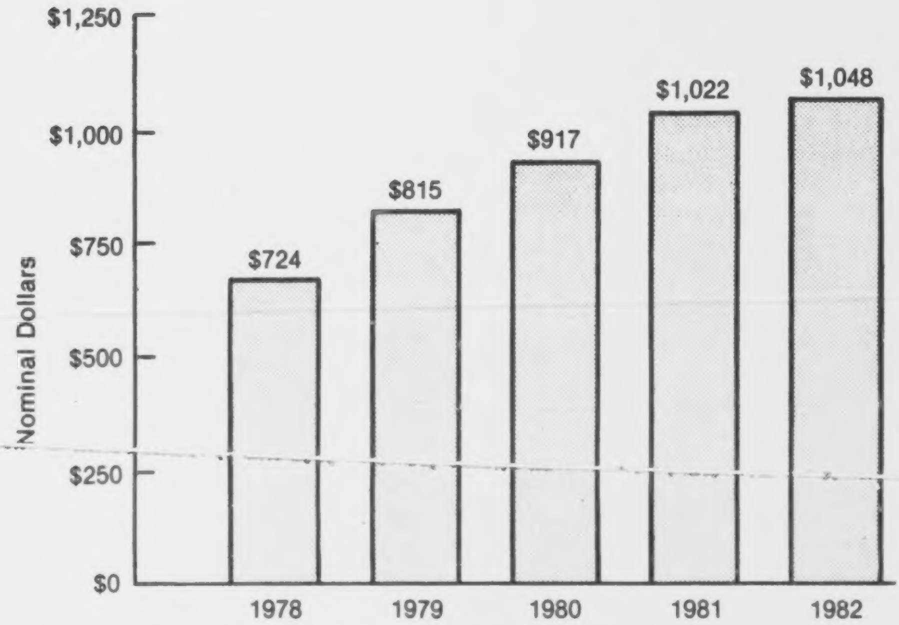
One of the major issues for low-income households is what proportion of their total household budget is being paid out for home energy costs, and to what extent has their real income kept up with energy inflation. The rise in energy costs in relation to income has been the impetus behind congressional enactment of both the Low-Income Energy Assistance Program and the Weatherization Program. Between 1972 and 1979, electricity costs rose 84 percent, natural gas prices increased 150 percent, and fuel oil costs rose 258 percent. These figures were well above the overall increase of 74 percent in the Consumer Price Index for the same period.

According to the Department of Energy's residential energy consumption survey, beginning in 1979 and continuing for the next 2 years, the average household paid $100 more each year for household energy. In 1982, however, the increase slowed significantly (see chart 1). As pointed out by DOE, this slowdown in the rate of increase occurred because the increase in prices was nearly offset by the decrease in consumption. Overall, prices rose 14 percent from 1981 to 1982, while consumption dropped 10 percent.

CHART 1

AVERAGE HOUSEHOLD EXPENDITURES FOR ALL MAJOR HOUSEHOLD FUELS - 1978 to 1982

(Nominal Dollars per Household)



Source: Energy Information Administration, 1978 to 1982 Residential Energy Consumption Surveys.

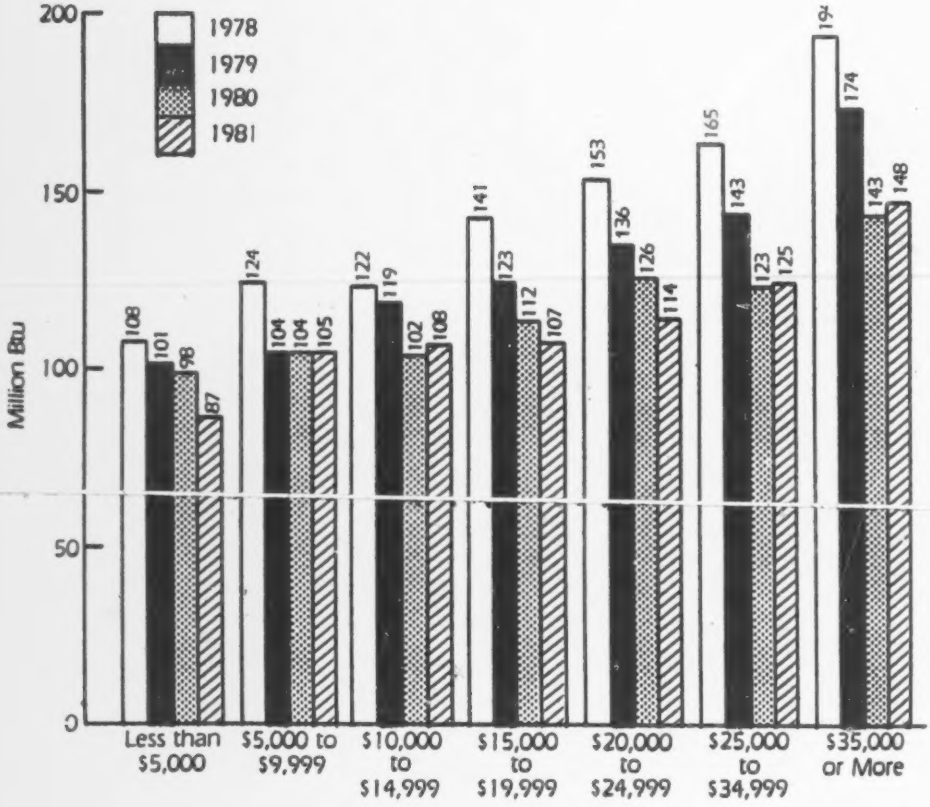
RECS: Consumption and Expenditures, April 1982 Through March 1983: National Data Energy Information Administration

The Department of Energy has estimated that energy consumption is higher for households with larger incomes. Chart 2 displays the average consumption of fuel per household by income class for the 4-year period 1978–81. There is a large difference in average energy consumption and expenditures among households with different incomes. The highest income households use about 70 percent more energy than the lowest income groups. It was noted that their living quarters are about twice the size of the lowest income group and they usually have more appliances. From 1978 to 1980, there was a trend toward parity, with high-income households lowering their energy consumption more than low-income households did. The data for 1981, however, show a slight reversal of this trend. Households earning less than $5,000 reduced their consumption by an estimated 11 million Btu, while households with incomes over $24,000 did not show a continued drop.

CHART 2

AVERAGE TOTAL ENERGY CONSUMPTION BY INCOME CLASS -- 1978-1981

(Million Btu per household)



Source: Energy Information Administration, 1978, 1979, 1980, and 1981 Residential Energy Consumption Surveys.

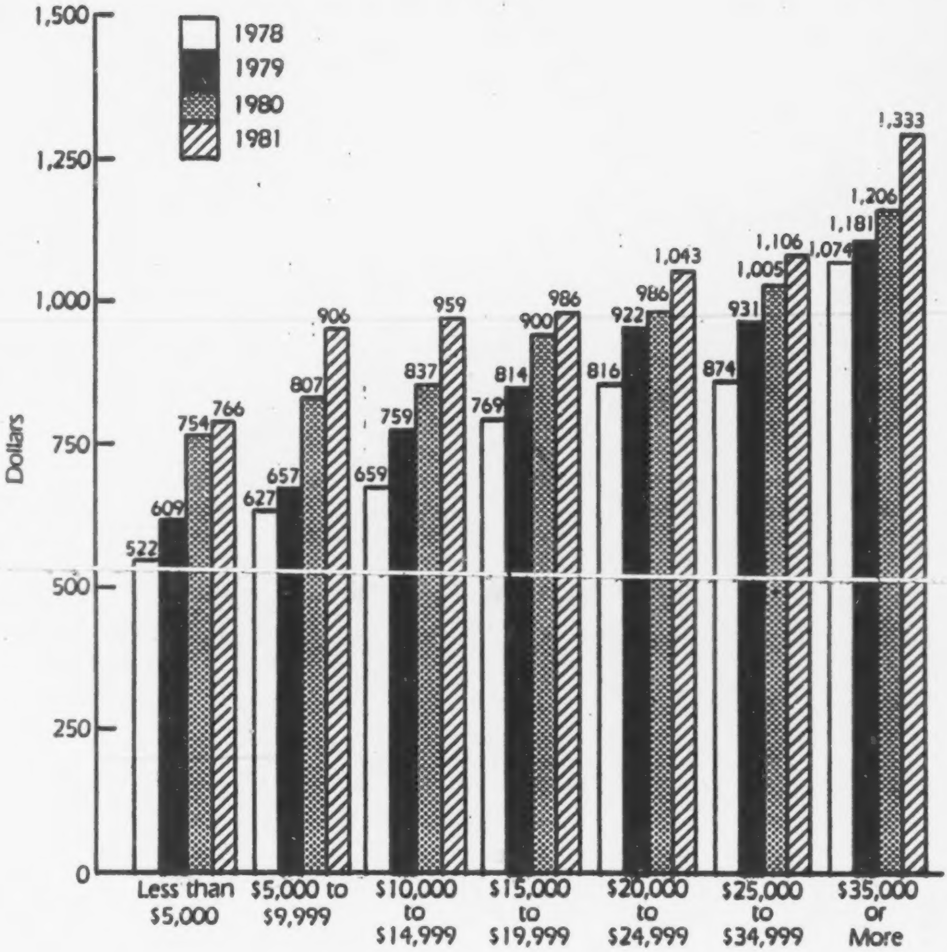
Rising energy prices affect all income groups, so that energy expenditures increased from 1978 to 1981 as shown in chart 3. Expenditures for households in the highest income group averaged $1,333, almost 75 percent more than expenditures of the lowest income group which were $766. In contrast, however, expenditures increased much more for the lower income group than for the higher.

CHART 3

AVERAGE TOTAL ENERGY EXPENDITURES

BY INCOME CLASS -- 1978-1981

(Nominal Dollars per Household)



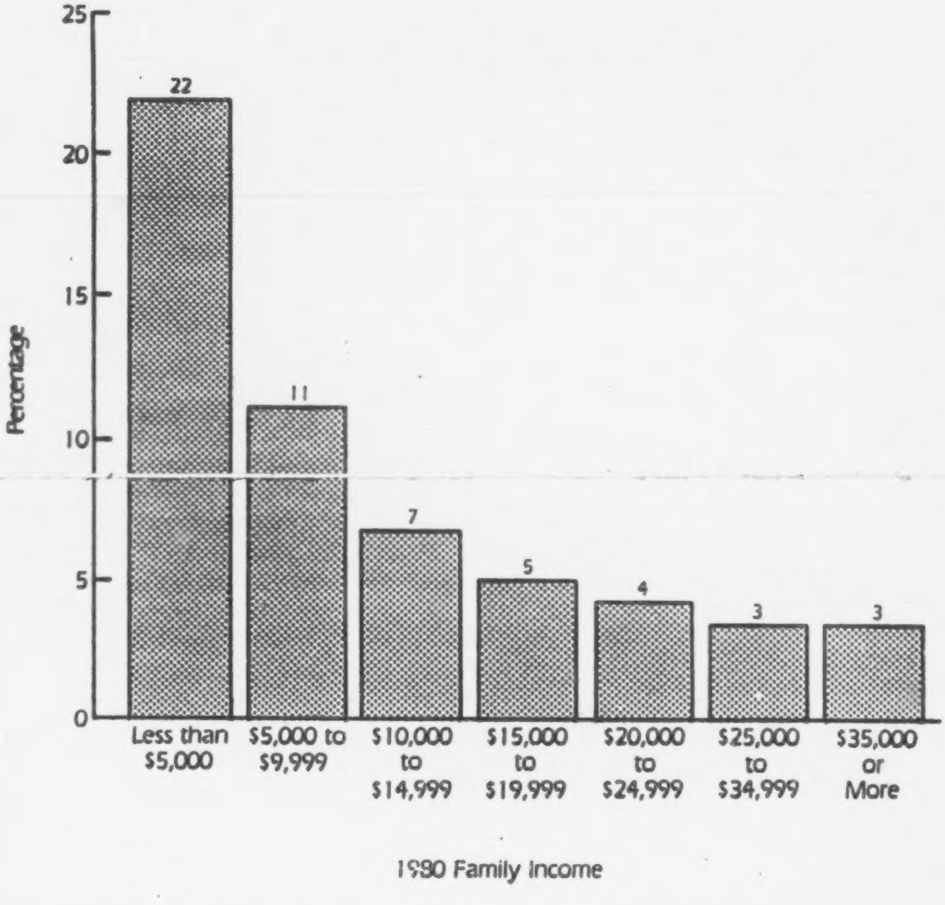
Source: Energy Information Administration, 1978, 1979, 1980, and 1981 Residential Energy Consumption Surveys.

During this 4-year period, beginning in 1978, expenditures for the lowest income group increased 47 percent, in nominal dollars, while expenditures for the higher income group increased 24 percent. Additionally, expenditures as a percentage of income are much higher for lower income groups, as shown in chart 4. Low-income households typically spent about 20 percent of their income on energy, while high income households spent from 3 to 4 percent of their income on energy. Among poor households, the burden of energy expenditures is highest in the Northeast and North-Central portions of the country. For example, in the Northeast, poor households, below 100 percent of the poverty level, paid 29 percent of their income for household energy.

CHART 4

PERCENTAGE OF INCOME SPENT ON HOUSEHOLD

ENERGY, BY INCOME CLASS -- 1981



Note: Household energy includes all uses of natural gas, electricity, fuel oil or kerosene, and LPG. It does not include motor gasoline.

Source: Energy Information Administration, 1981 Residential Energy Consumption Survey.

The situation is even worse for the low-income elderly because they are particularly susceptible to hypothermia—the potentially lethal lowering of body temperature. The Center for Environmental Physiology in Washington, DC, has reported that experts on this subject estimate that hypothermia may be the root cause of death for up to 25,000 elderly people each year. The center reports that most of these deaths occur after exposure to cool indoor temperatures rather than extreme cold. In addition, the situation can worsen many preexisting conditions and diseases in older adults, such as arthritis. Although another disease is ultimately listed as the cause of death, the center maintains that many deaths may be causally related to hypothermia.

B. LEGISLATIVE ACTIVITIES ON ENERGY ASSISTANCE AND WEATHERIZATION [1]

In recent years, congressional efforts to ease the burden of high energy costs on the elderly and poor have taken two principal forms. First, since 1977, Congress has appropriated money to provide aid for fuel related emergencies to households at or below 125 percent of the poverty line. The Low-Income Energy Assistance Program grew from $200 million in crisis assistance in 1977, to $2.075 billion in fiscal year 1984. Funds are distributed to States on a formula basis which takes into consideration climate and energy needs of the popluation.

Second, in 1975, Congress enacted the Emergency Energy Services Conservation Program, designed to provide energy relief to needy households by increasing the energy efficiency of homes through insulation and repairs. This has developed into a $190 million weatherization program operated and administered by the Department of Energy.

1. THE LOW-INCOME ENERGY ASSISTANCE PROGRAM

The precursors of the current Low-Income Energy Assistance Program were a series of 1-year programs in fiscal years 1977 to 1979 that were administered by the Community Service Administration [CSA]. Although the names and operation procedures of these programs differed year to year, they all were limited to a $200 million annual appropriation and oriented to crisis intervention. Generally, potential low-income recipients had to demonstrate that they faced an imminent energy-related emergency, such as a shutoff of their home heating fuel supply or a breakdown of their primary heating source. In such cases, aid could be provided to pay utility bills or provide in-kind benefits, such as space heaters or blankets.

Between the winter of 1979 and 1980, the price of home heating oil doubled. In response, Congress expanded aid sharply by creating a three-part energy assistance program at an appropriation level of $1.6 billion: $400 million in CSA for continuation of its crisis intervention programs; $400 million to the Department of Health and Human Services [DHHS] for one-time payments to recipients of supplemental security income [SSI]; and $800 million to DHHS for distribution as grants to States to provide supplemental energy allowances.

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[1] Information concerning legislation and issues related to the LIEAP and the Weatherization Programs comes, in part, from the U.S. Library of Congress. Congressional Research Service. Low-Income Energy Assistance Program Reauthorization Issues. Issue Brief IB84074 EPW, by Ken Cahill and Mary Pilote, March 6, 1984. Washington, 1984. And, Federal Weatherization Assistance for Low-Income Households. Report No. 83-96 EPW, by Evelyn Tager, May 12, 1983. Washington, 1983.

In 1980, Congress passed the Home Energy Assistance Act as part of the crude oil windfall profit tax legislation. Enactment of this law was based on the perception that those who would potentially suffer the most under decontrol, would be aided. The act authorized $3.12 billion for LIEAP in fiscal year 1981. During the appropriation process, however, the funding level and the distribution formula were changed. In its final form, $1.85 billion was appropriated, and the distribution to States was based on a complex formula that was heavily weighted toward States with cold climates and large fuel oil consumption.

Three basis types of energy-related aid are permissable under the LIEAP. First, States may make payments to assist households in paying their fuel bills for either heating or cooling. There are virtually no restrictions on the manner in which this assistance is provided (cash payments, vouchers, vender lines of credit, and tax credits are the most common). Second, States must use a reasonable amount of their allotment to provide energy-related emergency assistance, such as the provided under the old CSA crisis intervention program. Finally, States may use up to 15 percent of their allotments for low-cost weatherization. In an effort to provide greater flexibility, the law allows up to 10 percent of a State's allotment to be transferred from LIEAP to other Federal block grant programs and, conversely, funds may be transferred into LIEAP from other block grants.

During the second session of the 98th Congress, the LIEAP Program was reauthorizied as title VI of the Human Services Reauthorization Act [Public Law 98-558]. The law extends the program for 2 additional years at a level of $2.14 billion in fiscal year 1985 and $2.27 billion in fiscal year 1986. In addition, the law revises the formula for determining State allotments under the act by considering the percentage of expenditures for home energy by low-income household in that State to the expenditures in all States.

2. The DOE Weatherization Assistance Program

The Department of Energy Weatherization Program is authorized under the Energy Conservation and Production Act of 1976, as amended in 1979 and 1980. The program was extended through fiscal year 1984 under the Omnibus Budget Reconciliation Act of 1981, and is currently authorized by the first Supplemental Appropriations bill of 1984 [Public Law 98-181] through fiscal year 1985.

Under the DOE program, persons below 125 percent of poverty are eligible for assistance, and, similiar to the LIEAP Program, priority is given to the elderly and handicapped. Weatherization assistance is designed to help those households that lack the cash or credit with which to respond to the current incentives for conservation. The benefits of the program are fourfold:

First, improving the energy efficiency of a home provider greater comfort with less consumption.

Second, weatherization improvements are permanent—energy savings accrue each year on a one-time investment.

Third, reducing consumption reduces fuel bills for those low-income household, thereby lessening the demand for LIEAP funds.

Fourth, weatherization is a labor-intensive activity that employs low-income Americans. Studies show that for each $100 million in Federal dollars spent on weatherization, 5,200 jobs are created on-site or through related manufacturing industries.

The program has been administered through State energy offices, State economic opportunity offices, and locally through community action agencies [CAP's] and other. There has been a preference but not a mandated priority for CAP's, which remain the principal delivery system.

The Weatherization Assistance Program provides for the installation of insulation, storm windows and doors, and other energy efficiency improvements up to a $1,600 average per unit cost. The average unit costs is to be determined on a statewide basis.

In the past, the program has been criticized by the Congress and the General Accounting Office [GAO] for delays, poor performance, and management problems. One of the key obstacles to program success was the requirement that weatherization funds be used primarily for materials, which left inadequate funds for labor and program administration. With the phaseout of CETA the problem became more severe.

In general, despite delays in funding, the weatherization program has maintained its productivity. It is believed that the percentage of elderly participants has risen steadily. A recent study by the Consumer Energy Council of America found that weatherization efforts to be particularly successful in three critical areas.

First, in terms of energy savings, an average investment of $968 reduced energy consumption 26 percent, achieving savings almost as good as those realized in pure research conditions.

Second, in economic terms, low-income weatherization is more labor intensive than any fuel production option, creating more jobs per dollar invested.

Finally, as a social benefit, weatherization results in savings to low-income households of up to 27 percent in their fuel bills; this amounts to 4 percent of their average annual income. This benefit would increase as home fuel prices continue to increase. Although these savings are encouraging, recent studies (discussed later in this chapter) have begun to dispute the actual extent of both fuel and dollar savings in the program.

As mentioned previously, the Weatherization Program was reauthorized through fiscal year 1985 under the authority of a supplemental appropriation bill which was signed into law on November 30, 1983 [Public Law 98-181]. In addition, a series of programmatic improvements to the program were enacted during the second session of the 98th Congress. Under title IV of the Human Services Reauthorization Act of 1984 [Public Law 98-558], the Energy Conservation in Existing Buildings Act of 1976 was amended to make a number of changes to the Weatherization Program. These modifications include, among other things, revisions in eligibility levels based on eligibility criterion set forth under the LIEAP Program, inclusion of furnace modifications as eligible activities under the program, expansion of the limits for the per dwelling unit expenditures, and inclusion of a performance fund for States which demonstrate increased efficiencies in carrying out their Weatherization Program.

3. ISSUE ANALYSIS OF FEDERAL ENERGY PROGRAMS

(A) ELDERLY PARTICIPATION

Of primary concern to the Special Committee on Aging is the effectiveness of energy assistance programs in serving older persons. Both LIEAP and the Weatherization Programs require that elderly and handicapped citizens be given priority in receiving assistance. This provision was intended to assure that such households were aware that help was available, and to minimize the danger of unnecessary shutoff of utility services. In the last 3 years, project administrators and Federal department staff have observed that older persons are benefiting from these programs in greater numbers than in the past, although specific data on their numbers continues to be unavailable. Recent changes to the law relaxed many of the reporting requirements, and, as a result, many States opted to no longer maintain age-specific data. Although States have come up with a variety of means for implementing the targeting requirement, several aging organizations have suggested that Older American Act programs, especially senior centers, be utilized as information and outreach bases for the programs. Discussions with area agencies on aging and senior center staff indicates that increased effort has been made in recent years to identify eligible elderly persons for energy assistance.

In spite of this, many argue that the program has been well directed to the neediest. The Department of Energy's residential energy consumption survey consistently reports that low-income households spend a greater and increasing portion of their incomes on home energy than other households. In 1982, over 50 percent of the households receiving energy assistance had incomes below $6,000. Additionally, DHHS estimates indicate that about 40 percent of the households receiving energy assistance funds had a member 65 years of age or older.

(B) BLOCK GRANT VERSUS CATEGORICAL FUNDING

Another issue under consideration regarding the energy assistance programs concerns the issue of block grants versus categorical grants in the Federal weatherization program. Many public officials agree that the Federal Government should support weatherization activities for low-income households. The nature of this support, however, is somewhat controversial. While some groups favor the block grant approach to Federal assistance, others find more merit in the categorical grant approach like the DOE program. As noted earlier in this chapter, in the fiscal years 1983 and 1984 budget request, the President recommended terminating DOE's weatherization assistance program. In its place, the administration suggested that weatherization activities could be supported through block grants such as the DHHS Low-Income Home Energy Assistance Program and HUD's community development block grant. The administration argued that block grants provided States more flexibility in determining how funds should be spent. The General

Accounting Office [GAO], however, pointed out potential problems that could result from merging the weatherization program into a block grant. Among them was the lack of priority for weatherization within the block grant program, as compared to the DOE program, which could result in fewer homes being weatherized. GAO noted that a lack of restrictions on how funds may be used could result in communities not effectively targeting funds to address the greatest need. Additionally, GAO noted that no evidence existed to support the notion of reduced costs and improved quality under the block grant approach.

(C) EVALUATING ENERGY SAVINGS

Various studies have attempted to quantify energy savings resulting from Federal weatherization efforts. According to the GAO, it is difficult to measure such savings due to differing conditions of dwelling units and varying climatic conditions and fuel prices throughout the country. Additionally, little or no effort has been made to verify the accuracy of fuel-use records in home that have been weatherized. Experts in this area have noted that most studies do not use control groups where fuel costs in homes weatherized are compared with fuel costs in homes not weatherized. Lacking a control group, it is impossible to accurately predict whether changes in energy consumption are due entirely to weatherization assistance, or in part to changes in fuel prices, conservation programs, appeals from political leaders, or some combination of these. Further, it has been observed by program personnel that some households may conserve less after weatherization because they raise their thermostats to a more comfortable level.

According to GAO, the extent to which DOE's program is reducing energy costs and consumption is unknown by DOE and the States which administer the DOE program. While DOE claims a 20- to 25-percent annual energy savings in homes weatherized through its program, GAO reports that this statistic has questionable reliability because of DOE's sampling and data problems.[2]

A study conducted in the State of Minnesota on it's weatherization program employed a more scientific methodology to evaluate energy savings. Based on an analysis of fuel records from both weatherized and nonweatherized homes, the study concluded that the DOE program was successful in reducing energy consumption, on average, by 13 percent. The study also concluded that the cost of weatherization is likely to be repaid in terms of lower fuel fills within 3½ years.[3]

Although this evaluation initially showed promise for a careful examination of energy savings, the GAO reported that the study was too geographically limited to reveal savings on a nationwide basis. In the final analysis, GAO has concluded that there is no nationwide study on cost savings which incorporates standardized statistical methods in a way to assure maximum reliability.

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[2] U.S. General Accounting Office. Uncertain quality, energy, savings, and future production hamper the weatherization program; Report to the Congress by the Comptroller General of the United States. EMB 82-2. Oct. 26, 1982. Washington, 1982. pp. 18-20.

[3] Hirst, Eric, and Raj Talwar. "Reducing Energy Consumption in Low-Income Homes." Evaluation of the Weatherization Program in Minnesota. Evaluation Review, v. 5, October 1981. pp. 671-683.

C. AGING COMMITTEE ACTIVITIES ON ENERGY ASSISTANCE AND WEATHERIZATION

Since 1974, the Special Committee on Aging has responded to the particularly severe impact on older Americans of high energy costs, and has successfully documented the fact that the elderly are financially and physically affected by rising energy costs to a greater degree than other age groups. In addition, increases in energy and fuel costs have consistently and dramatically outstripped increases in the CPI and various indexed benefit programs, sometimes forcing older persons to choose between heating and eating. Over the last 10 years, the committee has been responsible for language in numerous pieces of energy assistance legislation mandating priority for the elderly, and for holding more than a dozen hearings that have examined the energy problems faced by older individuals and the Federal assistance initiatives designed to serve them.

During 1984, the committee was involved primarily in energy efforts designed to expand and improve the Federal weatherization program. In October 1983, Committee Chairman John Heinz introduced S. 1953, the Weatherization Act of 1983. This legislation proposed to amend the Energy Conservation in Existing Buildings Act of 1976 to reauthorize for 3 years the weatherization program. In addition, the bill would have improved the cost effectiveness of the existing program by allowing for furnace retrofitting and replacement of heating systems, and the application of other energy efficient technologies. The legislation also provided for improved planning on the part of DOE and the States in carrying out the program, expanded eligibility limits, increased the maximum per dwelling unit expenditure limits, and established a performance fund within DOE to be awarded to States operating efficient programs. S. 1953 was referred to the Senate Committee on Labor and Human Resources.

In addition to this legislation, other committee members were involved in introducing measures designed to improve the Weatherization Program. Senator Cohen introduced S. 2628 on May 3, 1984, as part of a larger package of energy legislation entitled the "Energy Efficient America Act of 1984." Cohen's bill was similar in many respects to S. 1953, but established a 10-year goal for the weatherization of all eligible units in the country, and substantially increased authorization levels for the program. This bill was also referred to the Committee on Labor and Human Resources.

On March 2, 1984, the Special Committee on Aging held a hearing entitled, "Energy and the Aged: Strategies for Improving the Federal Weatherization Program," which analyzed various methods for improving the program both from a public and private sector perspective. Senator David Pryor chaired the hearing. In his opening statement, Pryor noted the importance of Federal energy conservation programs and the need to maintain a national commitment to those most affected by energy inflation. Pryor also called for an expanded consideration of new energy efficient technologies which would increase the overall cost effectiveness of the

Weatherization Program. In most cases, witnesses at the hearing echoed this sentiment, and also attested to the overall ravages of skyrocketing fuel costs, dramatizing the particular problems facing the elderly. Support for expanding the list of eligible materials included in the Weatherization Program (that is, replacement burners, venting devices, and electrical or mechanical ignition systems), was expressed by both consumer groups and utility industry trade associations. Finally, the hearing focused on the administration's proposal to fund several energy conservation programs, including weatherization, from amounts resulting from petroleum pricing violations under the Emergency Petroleum Allocation Act of 1973.

Based on the efforts by committee members and the outcome of the March hearing, as well as an oversight hearing by the Senate Energy Committee, a number of program improvements to the DOE Weatherization Program were enacted as part of the Human Services Reauthorization Act of 1984 (Public Law 98-558). The details of these changes have already been discussed in this chapter.

D. CONCLUSION

Although Federal energy assistance programs have played an important role in helping millions of the Nation's poor to pay for their basic energy needs and weatherize their homes, current data shows a widening gap between the existing Federal resources and the needs of the population they were intended to serve. The last 4 years have seen encouraging developments from the private sector to help ease this burden. Private nonprofit community fuel funds as well as conservation efforts by many utility companies and fuel dealers have been growing. Nevertheless, energy expenditures on the part of poor families continue to grow.

The Community Action Foundation [CAF] recently reported that 4 million households had utility service terminated for nonpayment in 1982 alone. Additionally, CAF has pointed out that home energy expenditures for minimum consumption are up 106 percent since 1978, and 47 percent since the LIEAP Program was created in 1980. In the same period, funding for LIEAP has increased only 17 percent. To keep the percentage of real income devoted to energy by the poor the same as it was in 1978, $4.6 billion would have been needed in energy benefits alone in fiscal year 1984 to serve the eligible population. CAF estimates that if energy costs grow 2 percent a year, the eligible population would need $7.3 billion in 1989, just to keep purchasing power constant.

In contrast to these factors, the growing national mood toward fiscal austerity and concern over large budget deficits holds poor promise for increased Federal resource commitments in the immediate future. Although observers believe that these programs will continue to enjoy widespread congressional support, it is clear that new alternatives and expanded private efforts will be required to protect the needy against further deterioration of their incomes due to energy inflation.

Part V

SOCIAL SERVICES

Federal programs which support a broad range of services to older Americans today play an important role in the efforts to meet needs and expand opportunities. These programs provide funds to operate a wide variety of community and social services including senior centers, home health programs, counseling and case management, legal services, employment, education, transportation, and volunteer opportunities for older persons.

In contrast to the entitlement programs such as Social Security, Medicare, Medicaid, and food stamps, these programs are funded by discretionary appropriations from general revenues. In comparison to the entitlements, they constitute a much smaller portion of the Federal budget devoted to older Americans. Since 1981, these discretionary programs have been decreasing in relationship to gross national product. In part, this has resulted from the new policy directions of the current administration to curb Federal spending for domestic programs and return responsibility for such programs to State and local governments, as well as to the private sector. In the past 4 years, many of these programs have either leveled off or experienced substantial cuts as they have been folded into block grants. Others have been the target for total elimination.

The Federal Government entered the field of social insurance for needy individuals after the Great Depression of the 1930's had overwhelmed the resources of private, State, and local groups, which previously had been the sole provider of aid to the poor. The landmark Social Security Act of 1935 was targeted at easing the financial burden of aged and retired workers. Social services for the needy were not included in the original act, although it was later argued that cash alone would not meet all the needs of the poor. It wasn't until the midsixties that sufficient incentives and resources were established to thrust the Federal Government into providing social services in a major way. In the last 20 years, the share of the Federal budget devoted to the elderly has nearly doubled. In part, this growth has resulted from increases in the income security programs. Equally significant, however, were legislated improvements in health insurance and services for the elderly enacted in response to concerns about high rates of poverty and social isolation among older persons.

Despite hopes that expanded services to welfare recipients would ease demand on the cash assistance programs, the number of people considered at or below the poverty line continued to grow in the late sixties and early seventies. In response to the findings of the 1970 census that 1 in 4 elderly were poor, and recommendations from the 1971 White House Conference on Aging, Federal spending for social services increased substantially in the early seventies. Notable expansions were included in the title XX and the Older Americans Act programs. Funding for this expanded role of social services continued throughout the decade.

In the early eighties, however, the growth in the proportion of the Federal budget spent on social services slowed substantially. Budget cuts in the early 1980's had the greatest effect on discretionary domestic spending. Federal spending for programs providing social services to the elderly were affected less than other discretionary spending, but significant losses did occur.

In addition to budgetary questions, several other concerns have emerged in recent years as major public policy considerations in the area of the social services, and are likely to remain the focus of continued debate and study throughout the decade of the 1980's. Included among these important concerns are such issues as categorical versus block grant approach to funding social services; need versus age as a criterion for entitlement to services; and, the appropriate role of the community based long-term care system in meeting both the health and social service needs of the elderly. These issues are treated more extensively in the chapters that follow.

In the near future, Federal involvement in social services for older Americans will continue, although the extent of this involvement is much less certain. The growing national mood of fiscal austerity, coupled with an increasing uncertainty about the size of the Federal deficit have begun to lead the way in redirecting national priorities away from publicly supported social services and toward a renewed reliance on individual and private support. This trend toward a New Federalism in the social services is expected to continue into the future.

Chapter 11

OLDER AMERICANS ACT

OVERVIEW

For the past 19 years, the Older Americans Act has served as the cornerstone of Federal involvement in a wide array of community services to older persons. Created during a time of rising societal concern for the needs of the poor, the act marked the beginning of a categorical approach to programs specifically designed to meet the social and human needs of the elderly. The act itself was one of a series of Federal initiatives that were part of President Johnson's Great Society programs. These legislative initiatives grew out of a concern for the large percentage of older Americans who were impoverished, and a belief that greater Federal involvement was needed beyond the income transfer and health programs. Although older persons could receive services under a multiplicity of other Federal programs, the act became the first major vehicle for the organization and delivery of community based social services to the elderly.

The Older Americans Act followed on the heels of a similar but somewhat more expansive grouping of social service programs initiated under the Economic Opportunity Act of 1964. With a similar conceptual framework to that embodied in the Economic Opportunity Act, the Older Americans Act was established on the premise that decentralization of authority and the use of local control over policy and program decisions would create a more responsive service system at the community level.

When first enacted in 1965, the act established a series of broad policy objectives designed to meet the needs of older persons. These objectives, however, lacked both legislative authority and adequate appropriations to be truly effective. Despite its limited scope and funding—providing for a Federal Administration on Aging and making minimal grants to State units on aging—the act established a structure through which the Congress would later expand aging services.

The act grew slowly during the 1960's, but during the 1970's Congress followed-up on improvements in income transfer programs with significant modifications in services to the elderly. In 1973, for instance, Congress enacted significant expansions in services provided under the Older Americans Act to provide for the establishment of nutrition programs and area agencies on aging. Fiscal years 1978 and 1980 saw further improvements in the level of financial support directed toward Older Americans Act programs with the strengthening of the structures for providing community based services [AAA's], and the added emphasis on the provision of certain "hard" priority services.

This expansion trend continued until the early 1980's, when in response to the Reagan administration's policies to cut the size and scope of many Federal programs, the growth of overall OAA spending was slowed substantially, and for some programs was reversed. Major budget cutting emphasis during this time, however was placed on reductions in the income transfer and health programs (i.e., Medicare and Medicaid). The focus on the larger money items helped deflect budget cutting measures aimed at programs such as the Older Americans Act, although they were not entirely untouched. For example, between fiscal years 1981 and 1982, title IV funding for training, research, and discretionary programs in aging were cut by approximately 50 percent. Nevertheless, widespread congressional support for other OAA programs, especially nutrition and senior employment, served to protect them.

Over the years, the essential mission of the Older Americans Act has remained very much the same: provide a wide array of social and community services to those older persons in the greatest economic and social need in order to foster maximum independence. The key element in the program has been to help maintain and support older persons in their homes and communities, in the hopes of avoiding unnecessary and costly institutionalization.

States and area agencies on aging constitute the administrative structure for programs under the act. In addition to funding specific services, they have broad responsibilities to act as advocates on behalf of older persons and to plan for the effective development of a service system that will best meet these needs. Beyond this mission, and as originally conceived by the Congress, this system was meant to encompass both services funded under the act, as well as services supported by other Federal, State, and local programs. The concept of resources mobilization and coordination was an important element in the early development of the act.

Since its enactment, the act has evolved from a program of small grants and research projects to a network of 57 State units of aging, over 660 area agencies on aging, and approximately 15,000 community organizations providing supportive social and nutritional services to older adults. At the same time, appropriations for programs under the act have increased from $6.5 million in fiscal year 1966 to over $1 billion during fiscal year 1984.

Congress has reaffirmed its support for programs under the Older Americans Act on 10 occasions through passage of various reauthorizations bills. The most recent amendments to the act occurred during the 1984 fiscal year. Responding to time pressures prior to adjournment, as well as a pervasive feeling that Older American Act programs were operating effectively, Congress made only minor adjustments to the act. The new amendments to the act were signed into law [Public Law 98-459] by President Reagan on October 9, 1984.

A. MAJOR ISSUES IN OAA REAUTHORIZATION [1]

During both sessions of the 98th Congress, a series of issues on the various titles of the act were examined. In addition to meetings and discussions conducted by the Federal Council on Aging and the national aging organizations, a number of congressional hearings were held in Washington and throughout the country to review items of concern.

1. ORGANIZATIONAL STATUS OF AoA

Changes in the organizational status of the Administration on Aging [AoA] has frequently been an issue in consideration during reauthorization of the Older Americans Act. Currently, AoA is located within the Office of the Assistant Secretary for Human Development Services [OHDS]. The organizational status and its effect on the ability of AoA to carry out its broad advocacy, planning, and coordination activities for aging programs have been debated since the inception of the act in 1965.

Changing the current structure was considered by Congress during the 1981 reauthorization process. Many observers, including representatives of national aging organizations, believed that because of the magnitude of issues in the field of aging and because the goals of the Older Americans Act intersect with many other Federal programs, AoA's organizational status should be elevated to allow greater visibility and leverage for aging programs and policies. Others felt that it would be infeasible to raise the status of one organization responsibile for one human service group as compared with other groups, and that organizational status alone does not necessarily affect ability to be an effective advocate. Further, some observers felt that upgrading the position would not accomplish the objective of more effective aging policies unless significant authority were attached to the position and sufficient staff to support the position were added. Testifying before a joint hearing of the Special Committee on Aging and the Subcommittee on Aging of the Committee of Labor and Human Resources, Dr. Robert Binstock of Brandeis University suggested that large Federal expenditures on aging argue convincingly for an Assistant Secretary in the Department of Health and Human Services responsible for coordinating all of the Department's policies on aging and age relations, including the operations of the Social Security Administration, the Health Care Financing Administration, and all others. Binstock further noted:

> * * * We need to have a powerful administrative official, responsible for having an overview of policies on aging, for their differential implications for persons within the older population, and for the relevance of other social policies in shaping the conditions of old age.

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[1] Information concerning issues and legislation under the Older Americans Act comes, in part, from the U.S. Library of Congress. Congressional Research Service. Older Americans Act of 1965 as Amended: Major Provisions of Conference Agreement on 1984 Amendments. Report No. 84-763 EPW, by Carol O'Shaughnessy, Sept. 28, 1984. Washington, 1984.

During other hearings on the 1984 reauthorization a host of national aging organizations, including the National Association of State Units on Aging and the National Association of Area Agencies on Aging, recommended that the Commissioner on Aging be elevated to the level of an Assistant Secretary within HHS. In preparing recommendations on the act, the Federal Council on Aging did not support this position, but urged the Secretary of Health and Human Services and the Assistant Secretary of OHDS to provide the maximum support possible to the Commissioner on Aging to carry out the mandates under the act.

The House reauthorization bill, H.R. 4785, would have replaced AoA with an Office on Aging headed by a Commissioner directly responsible to the Secretary of HHS. Final conference agreement, though, retained the Administration on Aging, but requires a direct reporting relationship between the Commissioner and the Office of the Secretary and prohibits the Secretary from delegating any of the Commissioner's functions. The conference report noted that "the amendment assures that responsibility for Federal aging policy is placed in the Administration on Aging and not in the Office of Human Development Services * * * the Commissioner * * * would not be answerable or have a reporting relationship to any official other than the Secretary."

2. ROLE AND APPOINTMENT OF THE FEDERAL COUNCIL ON AGING

A second major amendment to title II of the act revises requirements for appointment of members of the Federal Council on Aging by requiring that members be appointed by both Houses of Congress as well as by the President. Previous law required that the Council be composed of 15 members appointed by the President with the advise and consent of the Senate and that the Council make recommendations to the President, the Secretary of HHS, and the Congress on Federal policies and activities related to the elderly.

To a great extent, the arguments supporting the appointment change were quite similar to those involved with the organizational status of the Administration on Aging. Many observers felt that the Council had lost its independence, and could not effectively advocate for overall aging policies since it was essentially housed inside the Office of the Assistant Secretary for Human Development Services. Additionally, it was asserted that under the former structure, the Council was directly responsible to the executive branch, and therefore, operated autonomously from the legislative branch.

Public Law 98-459 stipulates that a portion of the Council members be appointed by the President, a portion by the President pro tempore of the Senate, and a portion by the Speaker of the House of Representatives. In the Senate report on S. 2603, which was the Senate version of reauthorization, the committee noted that the change would "assure that both the President and the Congress have the benefit of the full range of expertise on matters related to the special needs of older Americans and issues relevant to the administration of Federal policies and activities affecting the elderly."

3. TITLE III: GRANTS TO STATES AND COMMUNITY PROGRAMS

Title III authorizes grants to State agencies on aging to develop a comprehensive and coordinated delivery system for supportive services and multipurpose senior centers for older persons. This system is intended to assist older persons attain maximum independence in a home environment, to remove individual and social barriers to economic and personal independence, and to provide services and care for the vulnerable elderly. Since the original passage of the act in 1965, the title III program has evolved from a funding source for social service programs to a planning vehicle for development of a comprehensive and coordinated service system with funding authority for a broad range of supportive services, nutrition, and multipurpose senior centers. Public Law 98-459 essentially retains the overall philosophy and structure of the title III program, with several modest changes and additions.

(A) TRANSFER OF FUNDS AMONG TITLE III CATEGORIES

The Reagan administration's plan for reauthorization proposed to consolidate the separately authorized title III programs. Under the proposal the separate programs for supportive services, congregate nutrition services, home-delivered nutrition services, the USDA commodity program, and State administration would be merged into a single award to States.

The rationale for the administration's plan was that consolidation would increase opportunities for flexibility by allowing States to determine the level of funding for supportive and nutrition services based on individual State needs. Additionally, they argued that the proposal was consistent with a trend among States to transfer funds among the separate funding categories. During the past 2 years, States have increasingly shifted funds between these separate programs, with a notable shift of funds from the congregate nutrition program to other components of title III. Congregate nutrition programs receive the greatest amount of funding of any program under the act. For example, in fiscal year 1983, over $38 million was transferred from the congregate program to either supportive services or home-delivered nutrition programs. The administration also argued that consolidation would eliminate some State paperwork burdens. States presently must notify the Commissioner on Aging when making transfers of funds among funding categories, an administrative procedure that would be eliminated if the programs were combined.

The Federal Council on Aging supported the administration's proposal for a total consolidation of funding categories, but most national aging groups favored retention of the current law provision of 20 percent. The National Association of State Units on Aging [NASUA] took a slightly different position, however, arguing that States should be allowed to transfer up to 25 percent of its funds between the separate allotments for supportive and nutrition services. NASUA's proposal would have required States to provide assurances that additional transferred funds would be targeted to community based long-term care services for the frail elderly.

During final consideration of S. 2603, Congress rejected the administration's proposals for consolidation, but did approve an amendment that went beyond even NASUA's recommendation to increase the State's ability to transfer funds between the separately alloted funds for supportive and nutrition services. The amendment allows a gradual increase in the amount of funds that can be transferred between the funding categories, from the current 20 percent, to 27 percent in fiscal year 1985, 29 percent in fiscal year 1986, and 30 percent in fiscal year 1987.

(B) TARGETING OF SERVICES UNDER THE ACT

Another issue during the 1984 reauthorization process was whether the act should be amended to more clearly focus on certain subgroups of older persons. During hearings on the act, some observers indicated that, in view of the limited resources available under the program and the special needs of certain groups of older persons, the act and its implementation should be targeted to such groups.

Title III currently requires that preference in providing supportive and nutrition services be given to those older persons with the "greatest economic and social needs." Although various provisions in regulations have required that special attention be given to certain groups, allotment of title III funds to States is based solely on the number of older persons in the State. While Congress has required that priority be given to persons of low income, legislative intent, as evidenced by committee reports on various reauthorizations, has included specific prohibitions of a means test for determining eligibility for title III services, and has always maintained that the act is open to all older persons in need of services. In addition, States are required to distribute funds according to a formula taking into account the geographical distribution of persons 60 years and over. AoA regulations require the State to include economic and/or social factors in the formula as well.

During the first session of the 98th Congress, the Senate Labor Committee's Subcommittee on Aging held a hearing on the issue of targeting resources based on economic or social need. Testimony ranged from those who indicated that the current legislation provided sufficient flexibility for State and local agencies to serve targeted groups, to those individuals and organizations who supported the concept that specific dollar set-asides be made to give priority to minority, Indian, and other limited English-speaking individuals. One witness expressed the view that targeting be based on the concept of functional capacities of older persons.

In response to these concerns, Public Law 98-459 made two changes designed to strengthen the greatest social and economic need provision.

First, the amendments require States to publish a more detailed disclosure statement on the State's intrastate funding formula. This statement would be subject to a review and comment period. In making this change, the Senate Committee on Labor and Human Resources noted:

> This requirement is intended to increase public knowledge of how a State agency has planned to distribute all resources made available under the act and to target re-

> sources to specific groups of older persons, as well as to increase State accountability for its funding decisions.

Second, the law is amended to require that State and area agencies provide assurances that special attention will be given to "older minority persons."

(C) THE AGING NETWORK AND COMMUNITY-BASED LONG-TERM CARE

Concern over the rising cost of health care for the elderly led to a closer examination of the role of State and area agencies on aging in the development of community-based long-term care. During 1983, the National Association of Area Agencies on Aging articulated a proposal that sets forth the view that area agencies should be required to coordinate and integrate all programs and funding for the elderly and to develop a client-centered assessment system to assure the accessibility of case management services as a primary component of community-based long-term care.

The issuance of this policy statement raised many questions about the future direction of the title III program relative to the development of such a long-term care system. Although the OAA has traditionally authorized a number of services which are vital components of a long-term care system, such as home care and home-delivered meal services, it is generally not considered to be a long-term care program.

In the broader context, the policy statement reflected a growing concern among health and social service provider groups about the future direction for the organization and delivery of long-term care. Contributing to this concern were factors related to the demography of aging, predictions about the future need for both institutional and community-based services, and waiting lists for nursing home beds, as home care and other community-based services in many localities. [See chapter 8 for further discussion of long-term care problems.]

Another important factor that emerged during 1984 was the impact of Medicare's prospective reimbursement system. Several observers noted that the DRG's (diagnostic related groups), which are the heart of the prospective system were putting pressure on hospitals to discharge patients early. A number of area agencies on aging noted that these early discharges were putting added strain on community programs, and that additional coordination and more precise management of the patient was necessary to assure quality care. Finally, one of the more important issues that emerged during the discussions was the concern regarding the current and future costs of such care. These factors have compelled some States to reorganize certain organizational and delivery components of long-term care under their control. In many cases, State and area agencies on aging have been significantly involved and have been in the forefront of such action.

In response to concerns about this role, the House bill contained two amendments, ultimately accepted in conference, requiring that area agencies facilitate coordination of community based long-term care services, emphasizing home care services and the development of a client-centered case management system. Additionally, the 1984 amendments require area agencies to involve long-term care providers in service coordination, and to involve the community in addressing the needs of the institutionalized.

(D) EXPANSION OF OTHER SUPPORTIVE SERVICES

In addition to the above mentioned changes, Public Law 98-459 creates several new services categories under title III-B. Services for families of victims of Alzheimer's disease, services to identify and treat elder abuse, and services designed to expand nutrition education are among the more important changes.

Noting that the emotional and physical stress experienced by family members caring for victims of Alzheimer's disease can be devastating, the amendments require each area agency on aging to give emphasis within the existing in-home priority services. Additionally, it requires AAA's to fund supportive service, including respite care services, for families of older persons with Alzheimer's and other neurological diseases and organic brain disorders. The Senate committee report accompanying this amendment noted that, "the underlying intent is to support the existing caregiving system in order to sustain the family caregiver to continue in that role as long as possible."

A second area of program expansion concerned the issue of elder abuse. In recent years, a number of congressional committees, including the Senate Special Committee on Aging, have provided substantial documentation of the scope of this problem. According to current estimates, 500,000 to 2.5 million older persons are victims of abuse each year. During the past 3 years, projects funded with title IV funds and coordinated by the Administration on Aging, have served to illustrate the extent of physical, emotional, and financial abuse of the elderly. Significantly, these projects have also demonstrated the effective and useful role that social services can provide in preventing and alleviating these forms of abuse.

In response to concern about the growing evidence of elder abuse, Public Law 98-459 authorizes State and area agencies to support elder abuse prevention activities. It further requires that AAA's identify agencies in their communities involved in the prevention, identification, and treatment of elder abuse, and determine the need for appropriate services. Other allowable services include public education, outreach, conferences, and referral of complaints to law enforcement or adult protective service agencies.

Finally, a new provision in 1984 requires that each State agency set aside some funds for the purpose of conducting health and nutrition education programs. In adding this new section, it was noted in the Senate committee report that "some health problems faced by older Americans can be prevented or ameliorated if older persons were more cognizant of certain health promotion and/or disease prevention practices, such as those related to dietary intake, stress management, physical fitness, and environmental awareness." The amendment requires that demonstration programs be conducted by at least one area agency in the State, and are to begin no later than September 30, 1986.

4. TITLE IV: TRAINING, RESEARCH, AND DEMONSTRATION

Title IV of the act authorizes appropriations for training, research, and demonstration programs in the field of aging. Over the past 4 years, this title has been most affected by budget reductions. Appropriations for title IV reached their height in fiscal year 1980 at a level of $54.3 million. From 1980 to 1982, however, the title experienced a 59-percent reduction in funding, and has been a continual target of the Reagan administration for further cuts. For example, the administration proposed an additional 77 percent reduction for title IV in fiscal year 1985.

In an effort to maintain and improve programs for research and training, Congress felt that certain programatic aspects of the title needed strengthening. Public Law 98-459 includes new language providing for a broad statement of purpose for title IV programs and specifies new requirements for dissemination of information about research, demonstrations, and training projects.

Two additional provisions were added to give special attention to the service needs of persons with Alzheimer's disease. First, the amendments require the Commissioner of AoA to give special consideration to projects on the recruitment and training of personnel and volunteers to assist Alzheimer's victims and their families. Second, under the demonstration authority, the Commissioner must give priority to projects meeting the supportive services needs of such persons.

Finally, responding to growing criticism about the coordinated discretionary grant program operated by the Office of Human Development Services, the new law strengthens restrictions of title IV funds by prohibiting them from being combined with other funds unless they are separately identified. Additionally it prohibits the Commissioner from delegating authority for administration of title IV funds to another party.

5. THE SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

The Senior Community Service Employment Program (title V) was designed to provide subsidized part-time community service jobs for unemployed persons age 55 and over who have low incomes. The basis for the current program was a demonstration program created during the 1960's under the Economic Opportunity Act. Over the years, title V has enjoyed wide congressional support, and has grown from a $10 million program that supported 3,800 enrollees in 1974, to a $319.5 million program that funds over 62,500 positions today. The senior community service employment program, administered by the Department of Labor [DOL], is one of two programs under the act not administered by AoA. As required by law, funds are provided to both national organizations and to States to carry out the program.

An issue for review in connection with reauthorization of title V was whether the program should continue to be administered by DOL, or whether the program should be transferred to AoA. In its 1984 budget request, the administration proposed to incorporate funds for the program under the administrative jurisdiction of AoA, to discontinue separate funding for title V in DOL, and to make a number of other program changes. No subsequent congressional action was taken on this proposal. Therefore, title V reminded under the authority of the DOL at the beginning of fiscal year 1984. As part of its proposal for reauthorization, the administration again submitted its suggestions to move title V out of DOL.

In response, the Subcommittee on Aging of the Senate Committee on Labor and Human Resources requested the General Accounting Office [GAO] to conduct a review of the program, including an identification of potential problems and concerns related to the proposed transfer of the program to DHHS. The GAO reported that program data indicated that the title V program was successfully meeting quantifiable goals established by both the legislation and by DOL regulations. Additionally, the GAO noted that it could find no studies, evaluations, or other documentary evidence to indicate that program effectiveness and coordination would increase if moved from the Labor Department. Finally, although several suggestions for improvements were made, neither GAO's study nor others indicated there were serious problems with the current program operations.

Supporters of the proposed shift of title V to DHHS, such as the Federal Council on Aging, indicated that the move would consolidate authority for the administration of all Older American Act programs within one Federal agency. The program has been criticized for a lack of coordination of employment activities between national organizations and State agencies. If administered by AoA, supporters asserted, the Commissioner on Aging might be in a stronger position to mandate coordination of national organization and State agency sponsored activities.

Opponents of the proposal maintained that AoA did not have the capacity to administer the program and, because it is an employment program, it was more properly located in DOL. National organizations opposed the administration's proposal because it would have phased out the funding for national organizations in favor of awards to State agencies on aging. Other observers raised concerns regarding the costs to the Federal Government necessary to effect such a transfer.

Ultimately, the 1984 amendments rejected the transfer proposal, but included stronger language to foster better coordination between the national organizations and States. The major change, however, under the 1984 amendments related to the establishment of an administrative cost cap for organizations operating title V programs. The cap will be 13.5 percent effective July 1, 1986, and 12 percent effective July 1, 1987. Projects may apply to the Secretary of Labor for a waiver of up to 15 percent administrative costs if the additional allowance is necessary to carry out the project. This change resulted from data compiled by the GAO report that showed for fiscal years 1982–83 the average percentage of Federal funds used for administrative expenses by all sponsors of the title V program was 11 percent, with a range of 6.1 to 16.4 percent. In making this change, the Senate committee noted that the legislation would bring more uniformity to the program, and allow more of the limited title V funds to be used to support employment position for needy older persons. Additionally, the committee pointed out that the cap was appropriate in view of the fact that the title III program operates under a statutorily imposed limit of the costs of area plan administration, which is set at 8.5 percent of the State title III allotment.

6. OTHER ISSUES

The 1984 amendments made several other changes to the law including modifications to the title VI program, establishment of a new title VII program, and changes to the Age Discrimination in Employment Act.

The purpose of the title VI program is to promote the delivery of supportive and nutrition services to older Indians that are comparable to services offered to other persons under title III. During fiscal year 1984, AoA made awards to 83 tribal organizations to carry out the title VI program. Public Law 98-459 made only one amendment in the title VI program that liberalizes requirements on eligibility of tribal organizations for funds. The amendment provides that a tribal organization is eligible for funds if it represents at least 60 older Indians, rather than 75 older Indians, as previously required.

In addition to the amendments to the existing titles of the act, Public Law 98-459 adds a new title VII. This title, the Older Americans Personal Health Education and Training Program, requires the Secretary of DHHS, through the Administration on Aging, to award funds to institutions of higher education to design and implement standardized health education and training programs for older persons. Congress authorized $8 million for this title.

Finally, the 1984 amendments amend the Age Discrimination in Employment Act [ADEA] by extending protections against such age discrimination to U.S. citizens who are employed by U.S. employers in a foreign country. The law also increases the annual private retirement benefit level from $27,000 to $44,000 for determination of exemption from provisions of the ADEA for persons in bona fide executive or high policymaking positions.

B. SUMMARY OF 1984 ACTIVITIES UNDER THE OAA

Authorizations for appropriations under the Older Americans Act Amendments of 1981 expired on September 30, 1984. Several measures to reauthorize the act were introduced during the 98th Congress, and considerable congressional oversight and hearings were held to examine both the progress and issues surrounding programs under the act.

Two major proposals were introduced during the second session of the 98th Congress, and eventually became the principal vehicles for congressional debate on reauthorization.

In the Senate, S. 2603 was introduced on April 26, 1984 by Senator Grassley and 32 other Senators. Among those included as principal cosponsors of the measures were Aging Committee Chairman John Heinz and Ranking Minority Member John Glenn. This measure was referred to the Committee on Labor and Human Resources, and reported favorably on May 15. The full Senate passed S. 2603 on May 24. Among other things, S. 2603 included a 3-year reauthorization, proposed a new structure for the appointment of members to the Federal Council on Aging, increased the allowable transfer between supportive and nutrition services from 20 to 30 percent, emphasized service priority to minority individuals, included supportive services to families of older individuals with Alzheimer's disease, made services designed to prevent elder abuse one of the priority services, and placed a cap of 12 percent on Federal funds that could be used for project administration under the title V program. In addition, the bill made several other changes designed to increase the effectiveness and efficiency of the programs.

In the House, H.R. 4785 was introduced by Representative Andrews on February 8, was ordered reported by the Committee on Education and Labor on April 26, and eventually passed by the full House on August 8. Like its counterpart in the Senate, the bill provided for a 3-year reauthorization. In addition, other selected provisions included strengthening the position of the Commissioner of AoA within the Department of Health and Human Services, requiring area agencies to conduct activities in community-based long-term care, and further defining the law on issues related to targeting of certain needy individuals. Additionally, the House bill included a new title that would establish community demonstration programs in health education and training for older persons.

The conference report on the Older American Act Amendments of 1984 was approved by the Senate and House on September 26 and signed by the President on October 9 as Public Law 98-459. The bill as approved by both Houses was one that fine tuned the act without making major changes in the operation of the program. To a great extent this reflected a mood in the Congress and among the aging network that programs had been operating in an effective manner, thereby mitigating any need for major restructuring. For example, several controversial proposals made by the administration to consolidate various parts of the supportive and nutrition programs under title III and the change the Federal administrative powers for the title V program were rejected by the Congress. In addition, during the reauthorization process, proposals to expand services dramatically were dismissed because of growing congressional concern regarding the size of the Federal budget deficit; as well as the scope of federally funded domestic programs in general.

C. OAA BUDGET ISSUES AND AUTHORIZATION LEVELS

The 1984 amendments to the Older Americans Act (Public Law 98-459) provided for the following authorization levels from fiscal year 1985 through fiscal year 1987:

TABLE 1.—AUTHORIZATIONS OF APPROPRIATIONS FOR OLDER AMERICANS ACT PUBLIC LAW 98-459

[In thousands of dollars]

	Fiscal year—		
	1985	1986	1987
Title II: Federal Council on Aging	200	200	200
Title III: Grants for State and community programs on aging:			
Supportive services and senior centers	325,700	343,600	361,500
Congregate nutrition services	360,800	376,500	395,000
Home-delivered nutrition services	69,100	72,000	75,500
U.S. Department of Agriculture commodities	[1] 120,800	[1] 125,900	[1] 132,000
Title IV: Training, research and discretionary projects and programs	28,200	29,800	31,400
Title V: Community service employment for older Americans	[2] 335,000	[2] 351,400	[2] 368,300

TABLE 1.—AUTHORIZATIONS OF APPROPRIATIONS FOR OLDER AMERICANS ACT PUBLIC LAW 98-459—Continued

[In thousands of dollars]

	Fiscal year—		
	1985	1986	1987
Title VI: Grants for Indian tribes	7,900	8,300	8,600
Title VII: Older Americans personal health education and training program	8,550	[3]	[3]

[1] Plus such additional sums as may be necessary to maintain the level of reimbursement for the number of meals served in 1983.

[2] Plus such sums as may be necessary to support at least 62,500 employment positions.

[3] Such sums as may be necessary.

The Reagan administration's fiscal year 1984 budget request included a total of $997.9 million for programs operated under the Older Americans Act. This represented a reduction of approximately $55.8 million from the fiscal year 1983 funding level. The largest decreases in program support were proposed in the title III program areas, where the administration advanced suggestions for a reduction of $33.7 million—a net reduction of approximately 5 percent. Additionally, the budget proposal recommended cuts in the title IV program of $17.2 million, which would have represented a loss of 77 percent from the current program funding.

In all cases, the proposals presented by the administration were rejected by the Congress. The fiscal year 1984 Labor, HHS, Education and Related Agencies Appropriations bill and a subsequent supplemental appropriations funded Older American Act programs at a level of $1.1 billion for fiscal year 1984. The following table provides a specific breakout by major title area:

TABLE 2.—*Older Americans Act appropriations, fiscal year 1984*

	In thousands
Title II: Federal Council on Aging	$175
Title III:	
Supportive services and senior centers	[2] 250,869
Nutrition services:	
Congregate	321,574
Home-delivered	[2] 67,025
USDA commodities [1]	116,000
State agency activities	21,673
Subtotal	(777,141)
Title IV: Training, research, and discretionary projects and programs	22,175
Title V: Community Service Employment	317,300
Title VI: Grants for Indian tribes	5,735
Total	1,122,526

[1] Administered by the Department of Agriculture. Fiscal year 1985 proposals include discontinuing this separate funding and including funding for this purpose in the Administration on Aging budget under a consolidated title III.

[2] Per Public Law 98-396, signed August 22, includes fiscal year 1984, supplemental funds, $10 million supportive services and $5 million for home-delivered meals.

In its fiscal year 1985 budget proposal, the Reagan administration again recommended reductions in funding for Older American Act programs. The proposed budget reduced programs by approximately $31 million, and, as noted above, called for the consolidation of the individual authorizations under title III. Congress again rejected the administration's proposal when it passed its regular appropriations bills for 1985. The conference reports on appropriations for the Departments of Labor, Health and Human Services, and Agriculture provide for $1.14 billion for all Older American Act programs in fiscal year 1985. The following table provides a specific breakout by title:

Table 3.—*Older Americans Act appropriations, fiscal year 1985 (Public Law 98-619)*

	In thousands
Title II: Federal Council on Aging	$200
Title III:	
Supportive service and senior centers	265,000
Nutrition services:	
Congregate	336,000
Home-delivered	67,900
USDA commodities	116,000
State agency activities	
Subtotal	(784,900)
Title IV: Training, research and discretionary projects and programs	25,000
Title V: Community service employment	326,000
Title VI: Grants for Indian tribes	7,500
Total	1,143,600

D. COMMITTEE ACTIVITIES DURING OAA REAUTHORIZATION

During both sessions of the 98th Congress, one of the most comprehensive hearing records for any reauthorization of the Older Americans Act was developed. In the Senate, a total of 13 separate hearings on issues ranging from age discrimination to the targeting of scarce resources under the act were conducted. With one exception, all hearings were held by the Subcommittee on Aging of the Committee on Labor and Human Resources.

The Senate Special Committee on Aging was also actively involved during the reauthorization process. In addition to 15 committee members joining as primary cosponsors of the reauthorization bill, several members presented direct testimony and recommendations on needed changes in the law. Early in the consideration, Chairman John Heinz submitted recommendations to the Committee on Labor and Human Resources. Among his suggestions, Heinz called for improving the appointment procedures to the Federal Council on Aging, strengthening services to victims of Alzheimer's disease, enhancing the coordination of the senior community services employment program, expanding resources for research and training in the field of aging, and improving community based services to older individuals who reside in Government sponsored housing projects. In addressing overall issues in the act, however, Senator Heinz noted that in view of the findings from the oversight hearings, this was not the time for an extensive overhaul of the act. Reflecting positive congressional sentimental on the status of Older Americans Act, he observed that older persons were indeed benefiting from the variety of programs that had been established in their communities.

On March 20, 1984, the Special Committee on Aging and the Subcommittee on Aging of the Committee on Labor and Human Resources held a final joint oversight hearing on remaining issues of concern for reauthorization. During the hearing, both Senators Heinz and Grassley discussed the value and opportunities that the act had provided in its 19-year history. Heinz stressed the importance of a strong advocacy effort on the part of the Administration on Aging, and the need for AoA to assume a stronger position for coordinating Federal programs and policies affecting the elderly. Senator John Glenn, the ranking minority member of the committee, noted the valuable role that the act has played in furthering the independence and self-sufficiency of older citizens. Additionally, Glenn noted that provisions in the act which insure citizen participation, minority rights, advocacy, and attention to the needs of the frail elderly must be preserved.

E. CONCLUSION

Fiscal year 1985 will mark the 20th anniversary of the Older Americans Act. When first enacted in 1965, the OAA set out a series of objectives aimed at improving the lives of older Americans in such areas as income, health, housing, employment, community services, and gerontological research. Since its inception the gradual evolution of the programs and services authorized by the act have been remarkable. Although progress has been realized, it has not been without some criticism.

As originally conceived the congressional intention underlying the Older Americans Act was to establish a coordinated and comprehensive system of services at the community level. Such a system, it was asserted, would provide opportunities for and assist vulnerable older persons who, despite advancements in income security and health programs, were still in need of social service support. Additionally, the structures would provide the supports necessary to promote independent living, and thereby reduce the risk of unnecessary institutionalization.

Major amendments to the act in 1972 and 1973 strengthened these provisions by creating the community structures—AAA's, nutrition projects—necessary to carry out the goals. Based on a conceptual design similar to the legislation that created local offices of economic opportunity, the act was organized on the premise that decentralization of authority and the emphasis on local control over policy direction and program decision would create more responsive systems at the community level. In essence, area agencies on aging would serve as prudent planners for older persons, who would ultimately benefit from comprehensive strategies of planning, coordination, and the elimination of service fragmentation.

Critics of the act have asserted that while the OAA has emphasized the need to secure dignity, social integration, and independence for the elderly, its actual implementation fosters a separate network of services that isolate and segregate older persons from the mainstream of America and other age groups.[2] Additionally, some have argued that the State and area agencies on aging lack the statutory mandate to perform the coordination and advocacy role necessary to provide services in an effective and efficient manner—reflecting a similar situation faced by the Administration on Aging at the national level. Some insist that it is beyond the capacity of these agencies to resolve the large-scale problems facing older persons such as adequate income, quality health care, affordable housing, employment opportunities, and the like. Many State and area agencies, they assert, are forced into the role of conduits for title III funds, and because of their placement in a larger bureaucracy, lack the political clout to effect substantive change.

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[2] Estes, Carrol L. The Aging Enterprise. San Francisco, Jossey-Bass Publishers, 1980. p. 19.

Despite these problems, in recent years there has been a growing movement at the State and area agency level to move beyond these narrowly defined roles into expanded areas of social and health policy which emphasize comprehensive service delivery to the vulnerable elderly. Limited resources and issues related to targeting have helped move the aging network in this direction. Major emphasis on the development of long-term care strategies, however, have provided the substance for many of these agencies to assume new roles in coordinating care systems at the community level. Assuming responsibilities for case management and preadmission assessment, and the development of community programs based on designs similar to the national channeling demonstration program have propelled State and area agencies into new functional areas. It is anticipated that this trend will continue in the future.

In the long run, the development of a national policy on aging under the Older Americans Act remains uncertain. Based on testimony presented during the 1984 reauthorization, it is clear that Congress will need to go beyond the incremental changes in reforming the act, to enhance and further the goals it set for itself and the Nation back in 1965.

Chapter 12

SOCIAL, COMMUNITY, AND LEGAL SERVICES

OVERVIEW

Social service programs funded by the Federal Government support a broad range of services to older Americans. These programs provide funds to operate a variety of community and social services including home health programs, legal services, education, transportation, and volunteer opportunities for older Americans.

In contrast to the entitlement programs—Social Security, SSI, food stamps, Medicare, Medicaid—the social services block grant, community services block grant, education and transportation programs, and legal services are funded by discretionary appropriations from general revenues. In fact, these services were created to bridge the service gaps left by cash benefit programs which could not meet all the needs of the elderly poor and disadvantaged. Today, spending for social services remains a very small portion of the Federal budget devoted to older Americans, with spending for health care accounting for the bulk of dollars expended for the elderly.

During the Reagan administration, two basic themes have emerged with respect to the delivery of social services for the elderly. First, the administration has sought to give States greater discretion in the administration of social services as part of its "New Federalism" initiatives. The Omnibus Budget Reconciliation Act of 1981 [OBRA] consolidated a network of categorical programs into block grants in the belief that the States could best target resources to areas of greatest need. OBRA established the social services block grant [SSBG] and the community services block grant [CSBG]. Second, the shift toward block grant funding has been accompanied by a general trend toward fiscal restraint and retrenchment. As a result, the competition for scarce resources has been accelerated between the elderly and other needy groups. In addition to the cuts accompanying the block grants, the administration has proposed to reduce spending for education, transportation, and legal services. Fiscal restraint in these programs has affected service delivery in varying degrees, with the most significant cuts coming in legal services, which the administration has sought to eliminate entirely. Older American Volunteer Programs [OAVP], in contrast, have enjoyed strong support from the administration. These programs utilize the skills and experience of older Americans to provide social and community services to needy persons of all ages.

In general, Congress has resisted the administration's efforts to reduce funding for social, community, and legal services. Following the cuts sustained in the fiscal year 1981 budget, Congress increased spending for the SSBG and CSBG, and in fiscal year 1985, increased significantly authorized spending levels for adult education and other education programs benefiting the elderly. In the near future, however, the focus on Federal spending will be framed by the widespread concern over budget deficits. The resolution of this debate may very well determine the Federal role in providing social services to the elderly in the years ahead.

A. SOCIAL SERVICES BLOCK GRANT

Social services programs are designed to protect individuals from abuse and neglect, help them become self-sufficient, and reduce the need for institutional care. Social services for welfare recipients were not included in the original Social Security Act, although it was later argued that cash benefits alone would not meet all the needs of the poor. Instead, services were provided and funded largely by State and local governments and private charitable agencies. The Federal Government began funding such programs under the Social Security Act in 1956 when Congress authorized a dollar-for-dollar match of State social services funding. Between 1962 and 1972, the Federal matching amount was increased and several program changes were made to encourge increased State spending. By 1972, a limit was placed on Federal social services spending because of rapidly rising costs. In 1975, a new title XX was added to the Social Security Act which consolidated various Federal social services programs and effectively centralized Federal administration.

Title XX provided 75 percent Federal financing for most social services, except family planning which was 90 percent federally funded and certain day care services which received 100 percent Federal funds. Training was also matched at a 75 percent Federal rate. Significantly, the law required that at least half of each State's Federal allotment be used for services to recipients of aid to families with dependent children [AFDC], supplemental security income [SSI], or Medicaid. The remaining funds could be used to provide services to anyone whose income did not exceed 115 percent of the State's median income. Fees were mandatory for individuals with incomes between 80 and 115 percent of the State median income. States also were required to follow a specified planning and public participation process.

In 1981, Congress created the social services block grant [SSBG] as part of the Omnibus Budget Reconciliation Act. By eliminating most of the restrictions in title XX, Congress granted the Reagan administration added flexibility to transfer maximum decisionmaking authority to the States. Under the SSBG, States are no longer required to provide a minimum level of services to AFDC, SSI, or Medicaid recipients, nor are Federal income eligibility limits imposed. Non-Federal matching requirements were eliminated, and Federal standards for services, particularly for child day care, also were dropped. The SSBG allows States to design their own mix of services and to establish their own eligibility requirements.

1. ISSUES

(A) STATE FUNDING PRIORITIES UNDER SSBG

The implementation of the SSBG was accompanied by reduced Federal funding. However, in recent years funding levels have been increased slightly. In fiscal year 1982, the national title XX appropriation was $2.4 billion, compared to $2.991 billion in fiscal year 1981—a decrease of 20 percent. Funding for fiscal year 1983 was $2.45 billion from SSBG plus an additional $225 million appropriated through the emergency jobs bill legislation.

The reduction in Federal funding for social services which accompanied implementation of the block grant increased pressure on State and local governments and service providers to maintain program delivery. In response to concern that certain groups, including the elderly, would suffer a reduction in services under the block grant, Congress ordered the General Accounting Office [GAO] to assess the implementation and administration of the new SSBG, and the effect of reduced Federal funding on program priorities. The GAO report was released in August 1984. Although Federal support decreased as States began implementing the SSBG, the GAO found that most States increased their total social services expenditures between 1981 and 1983. This increase was accomplished primarily through increased State and other non-Federal funding as well as transfers from other Federal block grant programs, such as the low-income home energy assistance block grant. This growth in expenditures, however, rarely kept pace with the increase in inflation during this period.

Generally, service areas funded under title XX continued to receive support in 1983 under the SSBG as States attempted to maintain program continuity. However, the reduced SSBG allocations caused States to reorder the priorities of individual service areas, reduce or eliminate services, and alter client eligibility criteria. GAO reported that States gave higher priority to adult and child protective services, adoption and foster care, home-based services, and family planning. The report also offered insight for better understanding the political debate over the block grant approach. The majority of State officials view the block grant as more flexible and less burdensome than prior programs. The majority of interest group representatives, however, believe that the block grant has resulted in a decrease in funding for social services and has had a generally negative impact on the interests of the groups they represent. While interest groups and State officials had differing views on the desirability of the block grant, both expressed concern about the Federal funding reductions that accompanied the block grant. Notably, many States believe that the advantages of the SSBG are diminished by reduced Federal funding, and that additional program discretion may be hampered by fiscal constraints imposed by the Federal Government.

(B) SSBG SERVICES AND THE ELDERLY

The role that the social services block grant plays in providing services to the elderly has been a major concern to policymakers. Supporters of the SSBG concept have noted that social services can be delivered more efficiently and effectively due to administrative savings and the simplification of Federal requirements. Critics, on the other hand, have opposed the block grant approach because of the broad discretion allowed to States and the loosening of Federal restrictions and targeting provisions that assure a certain level of services for vulnerable groups, including the elderly. In addition, critics have noted that any future reductions in SSBG funding could trigger uncertainty and increased competition between the elderly and other needy groups for scarce social service resources.

The extent of program participation on the part of the elderly under title XX was difficult to determine because programs were not age specific. States had a great deal of flexibility in reporting under the program, and as a result, it was difficult to identify the number of elderly persons served, as well as the type of services they received. The elimination of many of the reporting requirements under the social services block grant has made efforts to track services to the elderly even more difficult.

It is equally difficult to determine the degree to which SSBG dollars benefit the elderly. Based on the limited data that is available, the Office of Management and Budget estimated in 1981 that some 21 percent of the total title XX dollars went to services for the elderly. More recently, the National Data Base on Aging reported that SSBG funds comprised approximately 6.3 percent of State units on aging budgets and 4 percent of area agencies on aging budgets in 1982.

In addition to problems in determining funding amounts, little data exists on the national level indicating the extent to which SSBG programs are actually coordinated with other programs, or the extent to which services overlap.

The implications of the GAO study on SSBG services for the elderly are unclear due to the lack of programmatic data on State expenditures. GAO did report that funding for home-based services, which includes trained homemaker services, home maintenance and personal care services, home management services, and home health aid services, fluctuated among the States between 1981 and 1983. Some States reduced funding for these services by simply shifting program support to Medicaid. Florida, for example, chose to target their block grant dollars to disabled adults between the ages of 18 and 59, where previously, the State focused on all elderly and disabled persons. At the other end of the spectrum, Pennsylvania increased their emphasis on home-based services for the elderly as a means of preventing more costly institutionalization.

It seems clear that while funding for the SSBG has remained relatively constant, the potential for fierce competition among competing recipient groups is strongly indicated. Increasing social service needs along with declining support dollars portends a trend of continuing political struggle between the interests of elderly indigent and those of indigent mothers and children. In the coming years, a fiscal squeeze in social service programs could have massive political reverberations for Congress, the administration, and State governments as policymakers contend with issues of access and equity in the allocation of scarce resources.

2. LEGISLATIVE ACTIVITIES IN 1984

The 1981 Budget Reconciliation Act fixed authorization levels at 20 percent below fiscal year 1981 levels with slight increases for inflation. Authorization levels were set at $2.4 billion in fiscal year 1982, $2.45 billion in fiscal year 1983, $2.5 billion in fiscal year 1984, $2.6 billion in fiscal year 1985, and $2.7 billion in fiscal year 1986 and beyond. The program is permanently authorized. States are entitled to receive a share of the total according to their population size.

In the fiscal year 1984 budget request, the administration originally requested the fully authorized amount of $2.5 billion. However, the administration subsequently lowered its fiscal year 1984 request for the SSBG to $2.44 billion. At the same time, the White House proposed to terminate all funding for two related programs, the community services block grant and the work incentive program, and allow States to continue these activities using SSBG funds. No corresponding funding increase in the SSBG was proposed, however. The final Labor-HHS appropriations bill for fiscal year 1984 [Public Law 98-139] contained $2.675 billion for the SSBG program, which although higher than authorized, was identical to the appropriation level for fiscal year 1983. Congress also approved legislation to permanently increase the authorization level for the SSBG to $2.7 billion, effective in fiscal year 1984. Subsequently, a provision to bring fiscal year 1984 funding for the SSBG to the newly authorized level of $2.7 billion was included as part of a supplemental appropriations bill [H.R. 6040] passed by Congress and signed by President Reagan on August 22, 1984 [Public Law 98-396].

Although legislation was introduced in 1984 by Senator Moynihan and Representative Kennelly [S. 2492/H.R. 4970] to increase this amount further, to $3 billion in fiscal year 1985, $3.2 billion in fiscal year 1986, and $3.3 billion in fiscal year 1987 and future years, no action was taken on these bills.

Instead, the administration's request that the full entitlement amount of $2.7 billion be appropriated for the SSBG in fiscal year 1985 was approved by the House and Senate. The final version of the Labor-HHS-Education appropriations bill [H.R. 6028] passed Congress on October 10, 1984 and was signed into law on November 8 [Public Law 98-619]. Also, a continuing resolution containing an additional $25 million for the SSBG, specifically earmarked for child abuse prevention training, was signed by President Reagan on October 12, 1984 [Public Law 98-473].

B. COMMUNITY SERVICES BLOCK GRANT

The community services block grant [CSBG] is the current version of the Community Action Program [CAP], which was the centerpiece of the war on poverty of the 1960's. This program originally was administered by the Office of Economic Opportunity [OEO], a component of the Executive Office of the President. In 1975, OEO was renamed the Community Services Administration [CSA] and reestablished as an independent, executive branch agency.

As the cornerstone of OEO/CSA antipoverty activities, the Community Action Program, gave basic seed grants to local, private nonprofit or public organizations designated as the official antipoverty agency for a community. These community action agencies [CAAs] were directed to provide services and activities "having a measurable and potentially major" impact on the causes of poverty. During the 17-year history of OEO/CSA, numerous antipoverty programs were initiated and spun off to other Federal agencies, including Head Start, legal services, low income energy assistance and weatherization. The OEO budget peaked in fiscal year 1969 and 1970 with an annual funding of $1.9 billion. The funding then steadily declined until CSA's last year of existence in fiscal year 1981, when appropriations were $526.4 million.

Under a mandate to assure greater self-sufficiency for the elderly poor, CSA was instrumental in developing programs that assured access for older persons to existing health, welfare, employment, housing, legal, consumer, education, and other services. CSA programs designed to meet the needs of the elderly poor in local communities were carried out through a well-defined advocacy strategy which attempted to better integrate services at the State level and at the point of delivery.

I. Issues

(A) PROGRAM AND ADMINISTRATIVE CHANGES UNDER CSBG

In 1981, the Reagan administration proposed elimination of CSA and the consolidation of its activities with 11 other social services programs into a social services block grant as part of an overall effort to eliminate categorical programs and reduce Federal overhead. The administration proposed to fund this new block grant in fiscal year 1982 at about 75 percent of the 12 programs' combined spending levels in fiscal year 1981. Although the General Accounting Office and congressional oversight committees had criticized CSA as being inefficient and poorly administered, many in Congress opposed the complete dismantling of this antipoverty program. Consequently, the Congress in the Omnibus Reconciliation Act of 1981 abolished CSA as a separate agency but replaced it with the community services block grant [CSBG] to be administered by the newly created Office of Community Services under the Department of Health and Human Services.

Although Congress has enabled States to assume responsibility for administering the community services block grant, there has been a reluctance to eliminate the role of CAA's in the actual delivery of services to the community. The CSBG act requires States to submit an application to HHS, assuring that they will comply with certain requirements, and a plan showing how these assurances will be carried out. States must guarantee that the State legislatures will hold hearings on the use of funds each year. States also must agree to use block grants to promote self-sufficiency for low-income persons, to provide emergency food and nutrition services, to coordinate public and private social services programs, and to encourage the use of private sector entities in antipoverty activities. However, neither the plan nor the State application is subject to the approval of the Secretary. States may transfer up to 5 percent of their block grant allotment for use in other programs, such as the Older Americans Act, Headstart, and low-income energy assistance. No more than 5 percent of the funds may be used for administration.

Funding for the new block grant in fiscal year 1982 amounted to a 30-percent reduction from CSA's fiscal year 1981 appropriation. The CSBG received $348 million in fiscal year 1982, plus an additional $18 million for activities related to the phaseout of CSA.

Since States had not played a major role in antipoverty activities when the CSA existed, the Reconciliation Act offered States the option of not administering the new CSBG during fiscal year 1982. Instead, HHS would continue to fund the existing CSA grantees in those States until the States themselves were ready to take over the program. States which did not opt to administer the block grant in 1982 were required to use at least 90 percent of their allotment to fund existing community action agencies and other prior CSA grantees. In the act, this 90 percent passthrough requirement applied only during fiscal year 1982. However, in appropriations legislation for fiscal years 1983 and 1984, Congress extended the grandfather provision for CAA's and former CSA grantees in order to ensure program continuity and viability. The extension is viewed widely as an acknowledgement of the political stakes inherent to community action agencies and the programs they administer. Four States, Wyoming, Utah, Nevada, and Colorado qualified for an exemption because a significant portion of their counties were not served by an existing CAA.

After 2 years of existence, the administration proposed to terminate the CSBG entirely for fiscal year 1984, and to direct States to use other sources of funding for antipoverty programs, particularly SSBG dollars. In justifying this phaseout and suggesting funding through the SSBG, the administration maintained that States would gain greater flexibility because the SSBG suggested fewer restrictions. According to the administration, States would then be able to develop the mix of services and activities which were most appropriate to the unique social and economic needs of their residents. Congress, however, has continued to resist the administration's proposal and has continued to support funding for the CSBG, maintaining that the program is an effective antipoverty tool which would be blunted by incorporation into the SSBG.

Still, questions remain regarding the effect of the CSBG program on the range and quality of services delivered in the community. When Congress shifted the primary administrative responsibility of numerous CSA categorical programs to the States under the CSBG, States' discretionary authority dramatically expanded over their prior limited involvement in community action program activities. Under both the OEO and CSA, almost all community services grants were made directly to local providers. States' roles were essentially to provide liaison activities and other support functions, usually through grants to State economic opportunity offices. Few States had State-supported community services programs. Consequently, most States had no existing framework for planning community services. Given the States' limited experience in this area, and the reduction in Federal funding which accompanied the block grant, critics of the CSBG approach predicted adverse effects on program implementation and service delivery.

During 1982 and 1983, the General Accounting Office surveyed several States to assess the implementation and administration of the new CSBG, and the effect of reduced Federal funding on program delivery. The GAO report was released in September 1984. The substantial decline in Federal funding, which was not offset by the infusion of State funds, created numerous changes in CAA support, the GAO found. Although the 90-percent passthrough requirement provided some continuity in service delivery, the majority of CAA's sustained substantial funding reductions. Many providers have taken steps to compensate for reduced funds, such as charging fees, soliciting private contributions, seeking other Federal funding sources, and increasing the use of volunteers. The majority of providers, however, have reduced or eliminated services.

Several conclusions can be drawn from the GAO study. In general, States have not taken advantage of the expanded authority under the CSBG to make substantial programmatic changes. Instead, States have carried out their block grant management responsibilities by establishing program requirements, monitoring service providers, providing technical assistance, collecting data, and arranging for audits. However, the States' level of involvement in setting program priorities may increase as State administrative units acquire additional experience and knowledge of community service needs. The escalating demand for scarce community service dollars and the corresponding political pressue from interest groups, in turn, may threaten to splinter community action programs into disjointed and ineffective parts. Consequently, this shift in program discretion from the CAA's to centralized State units will require more thoughtful public discourse on the assignment of service priorities in order to ensure an equitable distribution of services under the block grant.

(B) CSBG SERVICES AND THE ELDERLY

The proportion of CSBG funds that support services for the elderly and the extent to which these services have fluctuated as a result of the block grant is unclear. When the CSBG was implemented, many of the requirements for data collection previously mandated and maintained under the Community Services Administration were eliminated. States were given broad flexibility in deciding the type of information they would collect under the grant. As a result of the minimal reporting requirements under the CSBG, there is very little information available at the Federal level regarding State use of block grant funds.

A 1984 study by the National Governors Association [NGA] on State use of fiscal year 1983 CSBG funds does provide some interesting clues, however. NGA found that CSBG's 90 percent passthrough requirement to CAA's effectively limited States' discretionary spending. Out of the more than 900 CAA's which had existed in 1981, 861 CAA's were receiving CSBG funds in fiscal year 1983. With respect of funding formulas, States allot funds based on any of the following: The amount received from CSA in fiscal year 1981; a straight formula based on the number of poor people in the communities served by the grantee; a minimum funding level plus an additional amount based on a poverty level. Most importantly, NGA received data on CSBG expenditures broken down by program category and number of persons served which provides some indication of the impact of CSBG services on the elderly (see table 1). For example, expenditures for employment services, which includes job training and referral services for the elderly, accounted for almost 13 percent of total expenditures and served over 400,000 persons. Housing programs, including home ownership counseling, shelters for the homeless, and construction of low-cost housing, served over 765,000 persons in fiscal year 1983, many of whom are elderly. A catchall program category supports a variety of services reaching older persons, including transportation services, medical and dental care, senior center programs, and information and referral for linkages with other programs. Emergency services such as donations of clothing, food and shelter, low-income energy assistance programs and weatherization are provided to the needy elderly through CSBG funds. Combined, these programs reached over 10 million needy persons in 1983. Unfortunately, data related to the age, sex, race, and income levels of program participants was not reported in the NGA survey. Until such data is analyzed, a definitive picture of the role CSBG programs play in assisting the needy elderly is unclear.

TABLE 1.—FISCAL 1983 CSBG EXPENDITURES AND PERSONS SERVED IN 34 STATES BY PROGRAM CATEGORY (SECTION D)

Program category	CSBG expenditure	Number of persons served
Employment	$25,189,314	433,141
In percent	12.8	1.6
Education	$11,540,553	3,456,287
In percent	5.9	12.9
Housing	$15,302,317	765,413
In percent	7.8	2.9
Better use of available income	$15,596,558	2,069,041
In percent	7.9	7.7
Emergency assistance	$20,435,408	2,408,978
In percent	10.4	9.0
Nutrition	$28,891,367	9,979,727
In percent	14.7	37.3
Linkages with other programs	$80,036,612	7,612,167
In percent	40.6	28.5
Total	$196,992,129	26,724,753
Total percent	100	100

2. LEGISLATIVE ACTIVITIES IN 1984

Congress continued to support incremental increases in funding for the CSBG in 1984, despite the administration's efforts to eliminate the program.

As established in the 1981 Omnibus Budget Reconciliation Act, the CSBG was scheduled to expire at the end of fiscal year 1986. Legislation to reauthorize CSBG, as well as the Head Start Program and the Low-Income Energy Assistance Program through 1987 (S. 2565), was approved by the Senate Labor and Human Resources Committee on May 9, 1984. In the House, the CSBG extension was included in a bill to reauthorize the Head Start and Follow Through Programs (H.R. 5145). However, the House failed to pass this measure. A second bill (H.R. 5885), which would not extend the CSBG beyond its expiration date but would increase authorization levels to $409 million in fiscal year 1985 and $429 million in fiscal year 1986, passed the House on June 26, 1984.

The House-passed bill contained several additional amendments not included in the Senate version which reflected House interest in greater congressional ovesight of the CSBG Program: The Secretary of HHS would be required, instead of authorized, to conduct compliance investigations in several States each year; the Director of the Office of Community Services would be subject to Presidential nomination and Seate confirmation; and programs for the elderly would be added to the Secretary's discretionary activities.

An amended version of S. 2565, which does not extend CSBG beyond its 1986 expiration date but increases authorization levels for spending in fiscal years 1985 and 1986, passed the Senate by a voice vote on October 4 and was passed by the House on October 9. President Reagan signed the measure on November 1 (Public Law 98-558). This final version of the legislation also extends or amends Head Start, Follow Through, several higher education programs, Low-Income Home Weatherization, Low-Income Energy Assistance and Native American Programs. Under the new law, CSBG spending levels are increased to $400 million in fiscal year 1985 and $415 million in fiscal year 1986. The requirement that States pass through at least 90 percent of their allotment to former CSA grantees and other eligible entities is made permanent by this legislation. However, up to 7 percent of the passthrough funds may be granted to an agency that had not been considered an eligible entity the previous year. This provision gives added flexibility to States who would prefer greater discretion on the use of their CSBG allotment, and reflects a compromise agreement reached between members of the Senate Labor and Human Resources Committee. Also, provisions were established for expanding services into areas not previously served by community action agencies under CSA, and for reviewing decisions of funding denials to grantees. States may increase eligibility criteria to 125 percent of the poverty line under the new law. Finally, the legislation authorizes $2.5 million for both fiscal year 1985 and 1986 for a Community Food and Nutrition Program. The purpose of CFNP is to support local community efforts to improve the delivery of direct nutritional assistance to low-income persons.

In fiscal year 1983, funding for the CSBG and related activities initially was set at $360.5 million. Of this amount, $316.7 million was earmarked for block grant purposes, and the remainder was used to fund various national activities, including rural housing programs, services for migrants and seasonal farmworkers, community economic development and the National Youth Sports Program for disadvantaged youth. All these activities are outgrowths of small programs operated by the former CSA. In fiscal year 1983, Congress provided an additional $25 million for the CSBG as part of an emergency job-creating supplemental appropriation [Public Law 98-8], bringing the total appropriation to $385.5 million.

In the fiscal year 1984 budget proposal, the Reagan administration requested no funding for the CSBG. Congress, however, insisted on continuing the program and appropriated $352.3 million for the CSBG. For fiscal year 1985, the administration resubmitted a proposal to terminate the CSBG and requested only $2.9 million for Federal activities necessary to close down the program. Once again, Congress rejected this proposal to cut off CSBG funding. The House passed its fiscal year 1985 Labor-HHS-Education spending bill [H.R. 6028], which contained $362.3 million for the CSBG on August 1. On September 25, the Senate passed an amended version of H.R. 6028 calling for $382 million for the CSBG.

The final conference report on the Labor-HHS-Education appropriations bill [H.R. 6028] contains a total of $372.4 million for the CSBG, an increase of $20.1 million over the fiscal year 1984 appropriation. The conference report was passed by both Houses on October 10. The President signed this measure into law on November 8, 1984 [Public Law 98-619].

C. EDUCATION

State and local governments have long had primary responsibility for the development, implementation, and administration of primary, secondary, higher education, and continuing education programs benefiting students of all ages. The role of the Federal Government in education has been to ensure equal educational opportunity, to enhance the quality of education, and to address national priorities in training.

Federal and State interest in developing education opportunities for older persons grew out of a paper prepared for the 1971 White House Conference on Aging which cited a hierarchy of educational needs for older persons. These range from the need to acquire the basic skills necessary to function in society, to the need to engage in activities throughout one's life which are enjoyable and meaningful and which benefit other people. The 1981 White House Conference on Aging report entitled, "Implications for Educational Systems," noted that as our society ages at an accelerated rate, it must assess and redefine the teaching and learning roles of older persons, and assure a match between the needs of older adults and the training of theose who prepare to serve them.

1. Issues

(A) EXPANDING EDUCATIONAL OPPORTUNITIES FOR OLDER ADULTS

While many strong arguments exist for the importance of formal and informal education opportunities for older persons, in reality, it has traditionally been a low priority in education policymaking. Public and private resources for the support of education have been directed primarily to the establishment and maintenance of programs for children and youth, including those of the traditional college ages. This is due largely to the perception of education as a foundation constructed in the early stages of human development—a kind of intellectual investment drawn upon for discrete withdrawals throughout one's adult life.

While formal education is viewed as a finite activity extending only through early adulthood, learning continues throughout one's life in experiences with work, family, and friends. Thus, it is a relatively new notion that a need exists for learning beyond the informal environment for the elderly. This need for structured learning may appeal among "returning students" who have not completed their formal education, older workers who require retraining in skills adaptable to rapid technological change, or retirees who desire to expand their knowledge and personal development. A growing awareness of the importance of education for the elderly has resulted in some reordering of priorities and resource allocation away from the basic education/literacy and training programs established for older adults in the early 1960's. While Federal programs have generally lagged, recently private and public-based education programs have emerged which are designed to better meet the growing educational needs of older persons.

(1) Elderhostel

Elderhostel was inspired by the youth hostels and folk schools of Europe, and is based on the conviction that retirement and later life represents an opportunity to enjoy new experiences. Elderhostels are short-term residential, campus-based educational programs provided to older persons at modest cost. Courses offered are in the liberal arts and sciences and presuppose no particular level of formal education on the part of the student. Most elderhostel programs deliberately avoid age-specific focus on the problems of aging.

Since the inception of elderhostel in New Hampshire in 1975, dramatically increasing numbers of older adults have enrolled in the programs. In 1984, over 700 private and public colleges and educational institutions in 50 States and Canada served 80,000 summer and academic year hostelers. In addition, over 5,000 hostelers participated in programs in Scandinavia, France, Germany, the Netherlands, Italy, and Great Britain. Even with the burgeoning numbers of participants, however, elderhostel remains essentially an educational opportunity reserved for mobile older adults with a relatively high education attainment level.

(2) Intergenerational Programs

Intergenerational programs in schools were introduced in the early 1970's in an effort to counter the trend toward an increasingly age-segregated society in which few opportunities exist for meaningful contact between older adults and youth. Initially, programs were designed and implemented with an emphasis toward providing the support, teaching and caring that would enhance the learning and development of schoolchildren. Eventually, intergenerational school programs emerged as a viable means of enriching the lives of older persons as well. Today, there are more than 100 intergenerational school programs nationwide. Over 250,000 volunteers participate in grades kindergarten through 12th.

Intergenerational school programs range from informal and haphazard to large, centrally organized programs reaching over several school districts. One such "model" program is the Senior Citizen

School Volunteer Program [SCSVP] established at the University of Pittsburgh as part of the Generations Together consortium of intergenerational programs. SCSVP is a nonprofit independent program that contracts with individual school systems which have demonstrated an interest in developing or maintaining a school volunteer program. In 1983–84, SCSVP placed some 345 volunteers over age 55 in over 60 schools in western Pennsylvania.

Whatever the size or scope, intergenerational school programs contribute immeasurably toward improving older persons' self-esteem and life satisfaction. School volunteering provides an opportunity for older persons to develop meaningful relationships with children, and to better cope with their own personal trauma, such as the death of a spouse or friend. These programs also allow schoolchildren to develop a more positive view of older persons and aging while benefiting from the social and academic experience of their older tutors.

The Federal role in promoting intergenerational school programs has expanded recently through a joint initiative sponsored by the Administration on Aging and the Administration for Children, Youth, and Families in the Department of Health and Human Services. This Federal effort consists of four major components: (1) Establishing an information bank of intergenerational program across the country; (2) disseminating this information to organizations interested in establishing such programs; (3) working with professional organizations to stimulate interest; and (4) funding intergenerational demonstration projects.

(3) Higher Education

Older persons bring insight, interest, and commitment to learning that can generate similar enthusiasm from younger classmates, and can add to the personal satisfaction of learning. A logical extension of the success of intergenerational school programs is the intergenerational classroom at the college level. A recent study found that younger students studying together with persons of their parents' and grandparents' age broadened their attitude toward older persons beyond rigid stereotypes and were able to identify them as peers. This finding rebukes the myth that older students somehow take away learning opportunities from younger students, and indicates a growing need to think of older adults as a vital part of the college classroom.

In response to this challenge, some colleges have designed continuing education programs to provide the flexibility and support older students often need when reentering college after several years. At Smith College, for example, the Ada Comstock Scholar Program offers a traditional education to women older than undergraduates of traditional age. Older students are fully integrated into the academic and campus life, although Ada Comstock students are allowed to take as long as they need or want to complete their college requirements. The older students, in return, bring an added dimension and vitality to the classroom by sharing their broad-based life experiences and interest in learning.

For those older students who cannot afford the cost of a private college, some States are moving to reduce the cost of higher education for adults age 60 and over. Although policies differ from State to State, most offer full tuition waiver and allow participants to take regular courses for credit in State-supported institutions. Since only two States provide reimbursement to individual institutions which waive tuition payments, the participating colleges must make substantial investments in terms of curricular emphasis and financial support toward meeting the needs of older students.

(4) Adult Education

The Department of Education is authorized under the Adult Education Act (Public Law 91-230) to provide funds for educational programs and support services benefiting all segments of the eligible adult population. The purpose of the act is to establish adult education progams that will enable adults 16 years and older to: (1) Acquire basic skills needed to function in society, and (2) assist them in continuing their education until completion of secondary level, if desired. Funds provided for adult education support State formula matching grants to combat functional illiteracy for adults over 16, and are distributed by a formula based on the number of adults in a State without high school diplomas who are not currently enrolled in school.

In 1977, a major change began in adult education enrollment. The enrollment of those aged 16 to 44 decreased while the enrollment of those aged 45 to 65 increased. A 1981 survey entitled "Participation in Adult Education" conducted by the National Center for Education Statistics revealed that 768,000 persons age 65 and older, or 3.1 percent of all older Americans, participated in educational activities. Although the majority of adult education participants are under 35, this marked the highest number and proportion of older people involved in adult education ever recorded by NCES. Even more dramatic—the number of persons 65 and older participating in adult education has almost tripled, growing at the average rate of 30 percent for every 3 years compared to an average rate of 12 percent for adult participation of all ages.

Nevertherless, with less than 5 percent of the elderly population enrolled in an educational institute in 1981, older people continue to be underrepresented in education programs in relation to their proportion to the total U.S. adult population. This is due partly to the fact that while older persons certainly have the ability to learn, the desire to learn is a function of educational experience. For example, the NCES reported in 1981 that the level of participation in adult education rose at each higher educational level from 2.2 percent of the total population with less than an eighth grade education to 31 percent with 5 years of college or more. Further, a 1981 NCOA/Harris survey supports this correlation between years of schooling completed and participation in adult education.

The existence of special classes and programs geared to older adults within structured adult education programs is still relatively rare except in community senior centers. Most of the classes focus on self-enrichment and life-coping skills and are gradually shifting to educational programs on self-sufficieny. Few programs currently exist to meet the growing demand for the skills needed for volunteer or paid work later in life. As the median years of schooling for older adults increases, and older persons look to continued employment as a source of economic security, adult education programs may need to shift their emphasis from "personal interest" courses to include job-training skills.

For the last 3 years, the Reagan administration has proposed consolidating Federal aid to vocational education and adult education programs into a simplified block grant to States. Concern has been raised, however, that this proposal ignores fundamental differences between vocational education—which serves those adults who require retraining for employment, and adult education—which acts as a basis for learning in later life, and would only weaken these successful programs. As a result, Congress has consistently rejected this proposal to simplify the program and increase States' discretion.

(B) ADULT LITERACY

Literacy means more than just the ability to read and write. Literacy is more clearly defined as the essential knowledge and skills necessary for effective functioning in the home, community, and workplace. According to some estimates, as many as 27 million Americans, or one in five adults, function with great difficulty in our society. An additional 47 million can function but not proficiently. These figures mean an astonishing 74 million Americans function in society at a marginal level or below. When the inherent problems associated with illiteracy are considered—unemployment, crime, homelessness, alcohol and drug abuse—the cost of widespread illiteracy in this country is staggering.

Of all adults, the group 60 years of age and older has the highest percentage of people who are functionally illiterate. Results of one study showed that 35 percent of adults 60 to 65 years of age lack the skills and knowledge necessary to cope successfully in today's society. These figures reflect the direct correlation between educational attainment and literacy. As would be expected, there is a heavy concentration of older persons among the groups of adults 16 years and over with less than a high school education. Of those with less than a high school education, more than three-quarters of those 65 and over have not completed grade school.

Generally, higher educational system in the United States have failed to address the needs of the older, illiterate adult. Although adult education programs exist throughout the country, less than 2 million participate in the programs, and most have a higher education level than the median for older adults. It has been suggested that Federal education programs designed to meet specific, categorical objectives have been responsible, in part, for the failure to prevent adult illiteracy. Advocates of the block grant approach toward social services funding, including the Reagan administration, have suggested that this approach would reduce administrative costs and increase overall coverage and flexibility in literacy initiatives. However, specific targeting requirements and regulations would need to be an integral part of any program consolidation because recent evidence indicates that adult education funds would be otherwise used to serve persons who require less extensive literacy training. In other words, the reduced payments which often accompany block grant funding could prove to be an incentive for States to allocate their scarce dollars to those persons who require less resources to train—those with better jobs, more education and higher incomes. The ambiguity surrounding the block grant approach makes any comprehensive reordering of literacy priorities problemmatic.

In response to the President's Commission on Excellence in Education report concerning the quality of education in America, the Reagan administration made the elimination of illiteracy a major focus in 1983 and 1984. The adult literacy initiative, sponsored by the Department of Education, is a largely promotional partnership with the private sector directed at: (1) Promoting a national awareness campaign; (2) establishing a literacy project for support at the State and local level; (3) promoting college credit and work-study assignments for literacy tutoring; and (4) establishing a corps of Federal employee literacy volunteers. In 1984, the National Institute of Education [NIE] launched the National Adult Literacy Project by awarding a $862,445 grant to Far West Laboratory of San Francisco, CA, to develop literacy training and research programs for adults.

2. Legislative Activities in 1984

Four major education bills were enacted in 1984 which, in part, are designed to provide educational assistance to older persons: Adult Education Act, Vocational Education Act, Library Services and Construction Act, and the Labor-HHS-Education appropriations bill. In supporting this education package, Congress sent a strong message of their commitment to allocate greater resources to improve access and quality of the Nation's educational systems.

On June 29, 1984, the Senate passed S. 2496, the Adult Education Act Amendments of 1984, as reported by the Senate Labor and Human Resources Committee [S. Rept. 98-503]. This act was later incorporated into an omnibus education reauthorization measure, H.R. 11, and approved by a House-Senate conference committee on October 1. The legislative package, renamed the Education Amendments of 1984, was signed by President Reagan on October 19 [Public Law 98-511].

Under the new law, Federal spending authorization for adult education is increased by 40 percent, from $100 million to $140 million in fiscal year 1985 and such sums as may be necessary for the three succeeding fiscal years. The amendments make a number of technical changes to the Adult Education Act, but continue the primary purpose of the AEA to assist States in providing literacy skills to educationally disadvantaged adults. Under previous law, section 309 of the AEA required the Secretary of Education to support various research projects, including activities which improve adult education opportunities for elderly persons; however, this section had never been funded. The new law requires that 5 percent of appropriations be set aside for activities authorized under this section, if AEA appropriations total $112 million or more.

Federal library funds are used to assist States in upgrading and extending library services. Libraries are viewed as an integral part of the national education system and commitment to lifelong learning. The Federal contribution to these programs, while relatively small, is critical to the ability of libraries to serve the total population, in particular the homebound, economically needy, and illiterate. Since the enactment of the LSCA in 1956, access to public library services has grown from 56 percent of the U.S. population to 96 percent in 1984.

The Library Services and Construction Act of 1984 [LSCA] extends authorization for such programs as library services, public library construction, and interlibrary cooperation through fiscal year 1989 and extends funding for library literacy programs through fiscal year 1988. The authorized spending level for all six titles of the LSCA is set at $156 million in fiscal year 1985, with small increases authorized in succeeding years. In addition to declaring in the purpose of the act the goal of improving State and local public library services for older Americans, the amendments added language to the Library Services Program—the core of the LSCA—which authorizes the following services for the elderly: (1) Training librarians to work with older Americans; (2) conducting special library programs for the elderly, especially those who are handicapped; (3) purchasing special materials for the elderly; (4) paying salaries of elderly persons who work in libraries as assistants in elderly library services programs; (5) providing in-home visits by librarians; (6) establishing outreach programs to alert the elderly about available services; and (7) furnishing transportation services.

The Carl D. Perkins Vocational Education Act [Public Law 98-524] represents a strong rejection of the administration's request to increase States' discretion in vocational education. Although the new bill reduces some of the planning requirements imposed on States, it also mandates new set-asides—money earmarked for improving vocational programs. In a key change, the ability of States and schools to use Federal money to maintain existing programs is strictly limited. The new bill includes a provision which emphasizes using Federal funds for innovation and updating vocational programs. This requirement reflects Congress' interest in the improvement and modernization of vocational programs.

The new act authorizes $950 million for the program in fiscal year 1985 and such sums as may be necessary through fiscal years 1989. An amendment offered by Representatives Biaggi and Ratchford was included in the final measure which establishes a grant program for model centers to focus attention on the special vocational education needs of persons 55 or older and to promote employment opportunities for older Americans. The centers are directed to provide training in growth industries which offer promising job potential and to provide information, counseling and support services to assist older persons in obtaining employment. Federal funding accounts for only about 8 percent of all vocational education support.

For the second consecutive year, Congress passed a regular Labor, HHS, Education appropriations bill. On August 1, the House passed its fiscal year 1985 package [H.R. 6028]. The Senate passed an amended version of this bill on September 25. The subsequent House-Senate conference report was agreed to by both houses on October 10, and signed by the President on November 8, 1984 [Public Law 98-619]. Under the spending bill, vocational education in fiscal year 1985 will be funded at $731,314,000; adult education will be appropriated $1 million—the fully authorized amount at the time of the bill's passage. The adult education reauthorization bill increases the authorization amount to $140 million in fiscal year 1985, and it is expected that supplemental appropriations will be made to reflect this additional spending authority.

For the third consecutive year, the administration proposed in 1985 to eliminate funding for the Department of Education library programs. Congress rejected this idea (see discussion of LSCA reauthorization above) and appropriated $125 million for this program in fiscal year 1985, of which $75 million is directed toward public library services.

3. FUTURE TRENDS

Rapid technological change in our society is intensifying the need for lifelong learning, and is placing a greater emphasis on acquiring new job skills. A major consideration in the issue of educating and retraining older workers is the projected labor shortage in the coming decades. For those older workers who view early retirement as an opportunity to change career direction, this trend represents an opportunity to remain an active and productive member of the work force. The linkage between older workers and the labor market, however, will require a commitment of resources for education, career counseling, and training.

While the legislation passed in 1984 reflects Congress' intent to support programs such as library services and adult education, the overwhelming majority of Federal dollars continues to fund programs for educationally disadvantaged children and youth. As part of their efforts to reduce Federal overhead, the Reagan administration has urged a reduced Federal role in education programs across the board. Thus, the intergenerational struggle that may emerge over scarce Federal resources between the burgeoning elderly population and historical benefactors—youth and children, will rest on such fundamental public policy issues as educational equity and access. The resolution of these critical issues will depend on the ability of each group to register their interests and demands with public policymakers at both the State and Federal level.

In order to adequately address the educational needs of older persons, greater attention needs to be devoted to providing the supportive services, such as transportation and career counseling, which help older students enjoy successful learning experiences. Federal, State, local, and private sector initiatives need to focus on the types of educational programs most suitable for older persons, and action needs to be taken to increase participation for those older adults with less education, especially the illiterate. With the graying of America, now seems the appropriate time to refocus our educational programs, and commit our resources to enhancing the educational opportunities of older persons.

D. OLDER AMERICAN VOLUNTEER PROGRAMS [OAVP]

1. Issues

In recent years, there has been a strong resurgence of interest in the role that volunteers can play in both the public and the private nonprofit community service delivery system. Volunteer service has been a traditional means by which individuals and organizations have helped to meet social and cultural needs in the society. Historically, volunteerism has been thought of as a commitment of time and resources to institutions and organizations such as hospitals, nursing homes, shelters for the homeless and abused, schools, churches, and other social service agencies. In more recent years, volunteer service has included activities for grassroots political advocacy and community improvement programs.

The Federal role in encouraging voluntary efforts has been coordinated through the ACTION agency. ACTION was established in 1971 under a reorganization plan which consolidated seven existing volunteer programs into a single independent agency. ACTION was granted statutory authority in 1973 under the Domestic Volunteer Service Act, which repealed previous legislative authorities for the component programs and authorized several new volunteer activities. Programs authorized under the DVSA and administered by ACTION include volunteers in service to America [VISTA], service learning programs, special volunteer programs, and the older American volunteer programs [OAVP]. Since its inception as a Federal program, ACTION agency volunteers have been involved in programs designed to reduce poverty, help the physically and mentally disabled, or serve in a variety of other community activities.

The need continues in many communities for volunteer efforts which address the problems of poverty and utilize the skills and experiences of others, notably the elderly. A central theme of the Reagan administration and a major focus of the President's Task Force on Private Sector Initiatives has been to encourage increased individual and corporate responsibility in meeting local economic and social service needs. As part of the President's New Federalism initiatives, increased emphasis has been placed on shifting funding and management responsibility for many community services from the Federal level to the State and local governments, and to the private sector. For example, the administration has proposed eliminating the community services block grant—the community action program designed to provide services which have a measurable impact on the causes of poverty—and replacing it with initiatives to encourage the development of private sector antipoverty activities. Notably, reduced funding for the CSBG in the last 3 years has resulted in greater reliance on volunteers rather than trained professionals to administer and implement services in the community. As this shift in Federal policy continues, greater pressure in helping to meet human needs will be directed toward the voluntary sector.

2. Programs

Volunteer efforts which address the problems of poverty, hunger and illness by utilizing the skills and experiences of older Americans are not only a necessary component toward meeting community and national needs, but a viable means of enriching and rewarding the lives of older persons as well.

The Older American Volunteer Program [OAVP], which includes the Retired Senior Volunteer Program [RSVP], the Foster Grandparent Program [FGP], and the Senior Companion Program [SCP], is the largest of the ACTION Program components. For fiscal year 1984, OAVP funding constituted 68 percent of total ACTION funding, and continues to support the majority of ACTION's volunteer strength. The various programs provide opportunities for persons 60 years of age and over to work part time in a variety of community service activities. Grants are awarded to local private nonprofit or public sponsoring agencies which recruit, place, supervise, and support older volunteers.

A significant facet of the OAVP is the extent to which Federal funding is supplemented by State and local resources. According to ACTION estimates, State funding to support ACTION-funded volunteer projects is estimated at over $16 million annually—$10 million for the FGP, and $3 million each for the Retired Senior Volunteer and Senior Companion Programs. In the past few years, State funds generated to support each of the programs have exceeded the Federal requirements for matching funds. ACTION estimates that States provided an average of 24 percent of total funds used under the FGP (compared to the requirement for 10 percent matching funds); an average of 23 percent of total funds under the SCP (compared to the Federal requirement of 10 percent matching funds); and an average of 40 percent under the RSVP (compared to the Federal requirement for between 10 to 30 percent matching funds, depending on age of project). To a great extent, the fact that these projects continue to generate additional funding at the State and local level and are a cost-effective means of providing community services, have made them enormously popular with both Congress and the administration.

(A) RETIRED SENIOR VOLUNTEER PROGRAM [RSVP]

RSVP was authorized in 1969 under the Older Americans Act. In 1971, the program was transferred from the Administration on Aging to ACTION, and in 1973, the program was incorporated under title II of the Domestic Volunteer Service Act. The program is designed to provide volunteer opportunites for persons 60 years and over in a variety of community settings. Volunteers serve in such areas as youth counseling, literacy enhancement, long-term care, crime prevention, refugee assistance, and housing rehabilitation. RSVP sponsors include State and local governments, universities and colleges, community organizations, and senior service groups. Each project is locally planned, operated and controlled. Although volunteers do not receive hourly stipends as under the Foster Grandparent and Senior Companion programs, they receive reimbursement for out-of-pocket expenses incurred as a result of volunteer activities.

The fiscal year 1984 appropriation of $27.4 million supported 355,000 volunteers in 724 projects throughout the country.

(B) FOSTER GRANDPARENT PROGRAM [FGP]

The FGP program was originally developed in 1965 as a cooperative effort between the Office of Economic Opportunity and the Administration on Aging. It was authorized under the Older Americans Act in 1969 and 2 years later transferred from the Administration on Aging to ACTION. In 1973, FGP was incorporated under title II of the Domestic Volunteer Service Act.

The FGP is designed to provide part time volunteer opportunities for low-income persons 60 years and over to assist them in providing supportive service to children with physical, mental, emotional, or social disabilities. Foster grandparents are placed with nonprofit sponsoring agencies such as schools, hospitals, day care centers, and institutions for the mentally or physically handicapped. Volunteers serve 20 hours a week and provide care on a one-to-one basis to three or four children. Under current law, a foster grandparent may continue to provide services to a mentally retarded persons over 21 years of age as long as that person was receiving services under the program prior to becoming 21.

Volunteers receive an hourly stipend, transportation assistance, an annual physical examination, insurance benefits, and meals when serving as volunteers. The Domestic Volunteer Service Act prohibits stipends from being subject to tax and from being treated as wages or compensation. Foster grandparent volunteers must have an income which is below the higher of 125 percent of the DHHS poverty guidelines, or 100 percent of those guidelines plus the amount each State supplements the Federal SSI payment. This annual income level is $6,225 for an individual in most States in 1984.

The fiscal year 1984 appropriation of $48.4 million supported 18,350 volunteers in 243 projects throughout the country.

(C) SENIOR COMPANION PROGRAM [SCP]

The SCP was authorized in 1973 by Public Law 93-113 and incorporated under title II, section 211(b) of the Domestic Volunteer Service Act of 1973. The Omnibus Budget Reconciliation Act of 1981 amended section 211 of the act to create a separate part C containing the authorization for the Senior Companion Program.

This program is designed to provide part time volunteer opportuniteis for low-income persons 60 years of age and over to assist them in providing supportive services to vulnerable, frail older persons. The volunteers assist homebound, chronically disabled older persons to maintain independent living arrangements in their own places of residence. Volunteers also provide services to institutionalized older persons. Senior Companions serve 20 hours a week and receive the same stipend and benefits as Foster Grandparents. In order to participate in the program, volunteers must meet the same income test as described above for the Foster Grandparent Program.

The fiscal year 1984 appropriation of $12.02 million supported 4,850 volunteers in 76 projects throughout the country, the same as in fiscal year 1983.

3. LEGISLATIVE ACTIVITIES IN 1984

Although both the House and Senate passed legislation in 1983 to extend for 3 years (through fiscal year 1986) the ACTION programs, consideration of the Domestic Volunteer Service Act amendment was delayed until 1984 due to continued controversy surrounding the VISTA Program. Critics of the program have long accused VISTA of involving volunteers in political advocacy activities and in politicizing Federal antipoverty initiatives. Although Congress has addressed these allegations periodically by clarifying intent and administration requirements, some Members have remained skeptical. In addition, the Reagan administration has repeatedly called for the elimination of VISTA, in part because of the program's history of alleged mismanagement and its association to President Johnson's war on poverty initiative. For the third consecutive year in a row, the administration proposed to eliminate VISTA in its fiscal year 1985 budget request. The administration charged that the program is minimally cost effective because it costs more to support VISTA volunteers than other ACTION-supported volunteers. The administration indicated that VISTA's annual per volunteer cost is $7,000, compared to an annualized Federal cost of approximately $3,000 for volunteers in Foster Grandparent and Senior Companion Programs. It has been pointed out, however, that VISTA volunteers work at least 40 hours per week compared with only 20 hours per week for hourly stipended Foster Grandparents and Senior Companions. Further, some proponents argue that VISTA is at least as cost-effective as the OAVP in generating additional outside resources and manpower.

Consequently, 1984 set the stage for a showdown between the administration and those Members of Congress calling for the elimination of VISTA and the promotion of nonstipended volunteers, and program supporters urging continuation and expanded funding for VISTA. Ultimately, compromises were reached prior to and following the conference committee meeting on February 28, 1984. A conference report finally emerged on April 5 containing assurances to continue the program with specific limitations on authorized volunteer activities. Congress approved the report and the measure was signed into law on May 21, 1984 [Public Law 98-288].

The Domestic Volunteer Service Act Amendments of 1984 reflect congressional interest in stimulating greater private sector resources and community volunteers as well as improving the administration and operation of ACTION programs. With regard to VISTA, the amendments emphasize that VISTA Programs should generate the commitment of private sector resources and encourage volunteer service at the local level. This provision reflects the Reagan administration's mandate to replace, to the extent possible, paid volunteers with a corps of private sector participants. Significantly, the new law includes a proposal included in the House bill to place greater reliance on the experiences and knowledge of older persons and to duplicate the success of the OAVP by requiring that at least 20 percent of all VISTA volunteers are age 55 years or older. (Presently, approximately 12 percent of all VISTA volunteers are over 55 years of age.) Also under the amendments, VISTA volunteer activities are expanded to include those related to problems of the homeless, jobless, and illiterate.

The new law makes the following changes to the Older American Volunteer Program: (1) Places a fixed ceiling of 30 percent on the amount of local contributions required from RSVP projects; there was concern that ACTION planned to raise this ceiling sometime in 1984 and that the smaller rural programs would not be able to generate additional local funds if a higher percentage were required; (2) raises the hourly stipend for Foster Grandparents and Senior Companions from $2 to $2.20, provided sufficient appropriations are available; and (3) restricts ACTION's authority over locally generated matching funds in excess of the amount required by law: that is, ACTION may not restrict the manner in which such contributions are expended. This restriction ensures adequate local, discretionary control over OAVP activities. Finally, new authorities were granted under the Senior Companion Program which emphasize the role of the OAVP in the overall delivery of quality community services. Under a newly authorized in-home health care program, ACTION is authorized to recruit trained personnel to serve as volunteer trainers (nonstipended). This program will allow SCP volunteers to assist in providing initial and continuing needs assessments and in-home services in cooperation with the health care system operating in each community. In addition, the authorized spending level for the SCP was increased for fiscal years 1984 and 1985 by over $12 million, to $28.2 million.

In 1984, Congress soundly rejected the administration's proposal to eliminate funding for VISTA in fiscal year 1985. Senate Appropriations Committee report language (S. Rept. 98-544) suggested strong support for this program by calling for the maintenance of at least 2,200 volunteers and by prohibiting ACTION from closing any State offices or reducing personnel. In addition, the report urged ACTION to undertake recruitment and public awareness efforts to provide adequate opportunities for persons of all age groups, geographic areas and economic levels to serve as VISTA volunteers. The subsequent House-Senate conference report on fiscal year 1985 Labor-HHS-Education appropriations (H.R. 6028 was passed by the House on August 1 and an amended version was approved by the Senate on September 25), which Congress approved on October 10, maintained this congressional support for VISTA. President Reagan signed this measure into law on November 8, 1984 [Public Law 98-619].

Under this legislation, VISTA was appropriated $17 million for fiscal year 1985, an increase of $5,169,000 over fiscal year 1984 appropriations and $11,200,000 more than the administration requested. Funding for the OAVP in fiscal year 1985 is set at the following levels: RSVP, $29.62 million; FGP, $56.1 million; and SCP, $18.08 million. A portion of the increased funding for the FGP and SCP are to be used to increase the stipend for volunteers from $2 per hour to $2.20 per hour. The remainder of SCP's increased appropriation is earmarked for an increase in the number of senior companion programs beyond the current 4,850. In addition, $3 million of the SCP appropriation is set aside for the new in-home health care program. The bill also includes a provision to preclude use of VISTA appropriations to close State or regional field offices. Total funding for ACTION in fiscal year 1985 is set at $150,164,000. This amount is $20,843,000 more than the fiscal year 1984 appropriation and is $29,947,000 more than the administration request.

E. TRANSPORTATION

Transportation is the vital connecting link between home and community. For the elderly and nonelderly alike, adequate transportation is necessary for the fulfillment of most basic needs; maintaining relations with friends and family, commuting to work, grocery shopping, and engaging in social and recreational activities. Housing, medical, financial, and social services are useful only to the extent that transportation can make them accessible to those in need. Transportation, then, serves both human and economic needs. It can enrich an older person's life by expanding opportunities for social interaction and community involvement, and it can support the individual's capacity for independent living, thus reducing or eliminating the need for institutional care.

1. ISSUES

(A) TRANSPORTATION SERVICES FOR THE RURAL ELDERLY

Transportation was cited as one of the major barriers facing the rural elderly in a report published by the Senate Special Committee on Aging in September 1984. According to the committee report, an estimated 7 to 9 million rural elderly lack adequate transportation and as a result, are severely limited in their ability to reach needed services. The isolation of rural areas, along with the more limited availability of resources and uncertainty of institutional support, makes the transportation problems of rural elderly more acute than their urban counterparts. Roads are sometimes narrow and poorly paved, further hampering travel for the rural elderly. Also, the rising cost of operating vehicles and inadequate reimbursement have contributed to the decline in the numbers of volunteers willing to transport the rural elderly. Lack of access to transportation in rural areas leads to an underutilization of programs specifically designed to serve older persons, such as adult education, congregate meal programs, and health promotion activities. Thus, the problems of service delivery to rural elderly are essentially problems of accessibility, not program design.

Lack of transportation for the rural elderly stems from several factors. First, the dispersion of rural populations over relatively large areas, complicates the design of a cost-effective, efficient public transit system. In addition, the incomes of the rural elderly generally are insufficient to afford the high fares which are necessary to support a rural transit system. Further, the physical design and service features of public transportation, such as high steps, narrow seating, and unreliable scheduling discourage participation by the elderly.

Generally, Federal transportation policy has not recognized the specialized needs of rural elderly. In an effort to draw attention to these critical transportation issues, specific recommendations were made during the 1981 White House Conference on Aging directed at improving rural transportation for the elderly. A miniconference on transportation for the aging which preceded the general conference recommended that State transportation agencies play a central role in developing responsive rural systems, with implementation for such a system initiated at the local level in order to ensure appropriate design for the unique needs of the individual community. The conference also recommended greater citizen participation at the policymaking level as well as at the advisory and implementation levels of transportation programs.

(B) TRANSPORTATION SERVICES FOR THE SUBURBAN ELDERLY

The graying of the suburbs is a phenomenon which has only recently received attention from policymakers in the aging field. Since their development following World War II, it has been assumed that the suburbs consisted mainly of young, upwardly mobile families. The decades that have elapsed since that time have changed entirely the profile of the average American suburb; the suburbs have aged with profound implications for social service design and delivery. In 1980, for the first time a greater number of persons over age 65 lived in the suburbs, 10.1 million, than in central cities, 8.1 million.

The availability of transportation services for the elderly suburban dweller is limited. Unlike large metropolitan cities where dense population patterns can facilitate central transit systems, the lack of a central downtown precludes development of a coordinated mass transit system in most suburbs. The sprawling geographical nature of suburbs makes the cost of developing and operating mass transportation systems prohibitive. Further, the trend toward retrenchment and fiscal restraint by the Federal Government has impacted significantly on the development of transportation services generally. Consequently, Federal support for primary transit systems designed especially for the elderly suburban dweller is almost nonexistent, and consists mostly as a supportive service. State and local governments have been unable to harness sufficient resources to fund costly transportation systems independent of Federal support. Often, alternative revenue sources are not politically expedient. For example, user fees alone are insufficient to support suburbanwide services and are generally viewed as penalizing those persons who are in most need of transportation services in the community—the elderly poor.

In 1984, researchers at the State University of New York in Albany received a grant from the National Institute of Child Health and Human Development to study the implications of older suburban populations on public policy, including transportation services. Their studies show that suburbs with a larger number of elderly have adjusted to the needs of their dependent populations by providing substantially higher levels of municipal services than the typical suburb. However, this has been accomplished through a heavy reliance on high property taxes. The fact that communities with the greatest demand for services for the elderly are precisely the communities that lack a tax base to support these expenditures has intensified this fiscal squeeze; many have already reached the constitutional limit on taxing authority. Thus, other sources of revenue are being tapped, such as lotteries and user fees, to help fund these additional community services.

The fact that the suburbs have aged has several implications for transportation policy and the elderly. The dispersion of older persons over a suburban landscape poses a unique challenge for community planners who have specialized in providing services to younger, more mobile dwellers. Transportation to and from service providers is a particularly critical need. Institutions which serve the needs of elderly persons, such as hospitals, senior centers, and convenience stores must necessarily be designed with supportive transportation services in mind. Further, service providers must provide transportation services for their elderly clients. Primary transportation systems, or mass transit, must ensure accessibility from all perimeters of the suburban community in order to adequately serve the dispersed elderly population. The demand for transportation services should be measured to determine the feasibility of alternative systems such as dial-a-ride and van pools. Alternative funding mechanisms such as reduced fares, user fees, and the local tax based need to be examined for equity and viability. Also, the public should be informed of the transportation services available through a coordinated public information network within the community.

The aging suburb trend will increase in the decades to come. It is clear that to the degree that the elderly are denied access to transportation, they are denied access to social services. If community services are to meet the growing social and economic needs for the older suburban dweller, transportation planning and priorities will demand reexamination.

(C) FEDERAL RESPONSE

Three strategies have marked the Federal Government's role in providing transportation services to the elderly: Direct provision—funding capital and operating costs for transit systems, reimbursement for transportation costs, and fare reduction. As part of the New Federalism initiative, the Reagan administration proposed in 1984 to eliminate Federal operating subsidies to States for transportation programs. This proposal was indicative of the trend to shift fiscal responsibility for transportation programs to the States and of a general retrenchment on the part of the Federal Government to support further transportation systems.

The major federally sponsored transportation programs that provide assistance to the elderly and handicapped are administered by the Department of Health and Human Services [HHS] and the Department of Transportation [DOT]. Under HHS, a number of programs provide specialized transportation services for the elderly. These include title III of the Older Americans Act, the social services block grant, the community services block grant, and to a limited extent Medicaid, which will reimburse elderly poor for transportation costs to medical facilities. Under the CSBG, more dollars are spent on so-called linkages with other programs—including transportation for the elderly and handicapped which links clients to senior centers, community and medical services, than on any other program category—over $80 million in fiscal year 1983.

The passage of the Older Americans Act [OAA] of 1965 has had a major impact on the development of transportation for older persons. Under title III of the OAA, States are required to spend an adequate proportion of their title III-B funds on three categories: Access services (transportation and other supportive services); inhome services, and legal services. In fiscal year 1983, transportation services alone comprised 9.4 percent of area agency on aging total service expenditures. This level of spending is a clear indication of the demand for transportation services by the elderly at the local level and the extent to which this network of supportive services provides assistance and relief to needy elderly nationwide.

The passage of the 1970 amendments to the Urban Mass Transit Act of 1964, sections 16(a) and 16(b) (Public Law 98-453), marked the beginning of special efforts to plan, design, and set aside funds for the purpose of modifying transportation facilities for improved access by the elderly and handicapped. section 16 of UMTA declares it to be the national policy that elderly and handicapped persons have the same rights as other persons to utilize mass transportation facilities and services; that special efforts shall be made in the planning and design of mass transportation facilities and services so that the availability to the elderly and handicapped persons of mass transportation will be assured; and that all Federal programs offering assistance in the field of mass transportation should contain provisions implementing this policy. Essentially, the goal of section 16 programs is to provide assistance in meeting the transportation needs of elderly and handicapped persons where public transportation services are unavailable, insufficient or inappropriate.

Another significant initiative in the last decade was the enactment of the National Mass Transportation Assistance Act of 1974 [Public Law 93-503] which amended UMTA to provide mass transit funding for urban and nonurban areas nationwide through block grants. Under the program, block grant moneys can be used for capital operating purchases at the localities' discretion. The act also requires transit authorities to reduce fares by 50 percent for the elderly and handicapped during offpeak hours. Also, passage of the Surface Transportation Assistance Act of 1978 provided funding at the Federal level to support public transportation program costs, both operating and capital for nonurbanized areas.

The programs administered by HHS have proven highly successful in providing limited supportive transportation services necessary for linking needy elderly and handicapped persons to social services in urban and suburban areas. The DOT programs have been the major force behind mass transit construction nationwide and continue to provide basic funding sources for primary transportation services for older Americans. Despite these program initiatives, however, Federal strategy in transportation remains essentially one of providing "seed money" for local communities to design, implement and administer transportation systems unique to their individual needs and resources. In the future, the Federal response to the increasing need for specialized services for the elderly and handicapped will dictate the range of services available and to a large extent, the fiscal responsibility of State and local communities to finance both large-scale mass transit systems and smaller neighborhood shuttle services.

2. CONGRESSIONAL ACTION IN 1984

Both House and Senate Appropriations Committees approved bills for transportation funding in fiscal year 1985 [H.R. 5921/S. 2852]. A conference committee, however, was unable to resolve a jurisdictional dispute which erupted between the House Appropriations Committee and Public Works and Transportation Committee. Consequently, no further action was taken on the regular appropriations bill. Instead, funding for transportation programs was included in the continuing appropriations resolution signed by the President on October 12, 1984 [Public Law 98-473]. Funding was set at a level of $11.6 billion for the Department of Transportation and related agencies in fiscal year 1985, an increase of $503.3 million over fiscal year 1984 funding. The bill provides $26 million in Federal mass transit funds to the States for transportation assistance for elderly and handicapped persons, including such capital expenses as buses, vans, wheelchair lifts, and communications equipment. Although Congress again rejected the administration's attempt to end operating subsidies, the conference report noted Congress' intent to relinquish greater financial responsibility to State and local governments.

3. FUTURE TRENDS

The demographic and social changes anticipated in the coming decades will have profound implications for planning and implementating social services for the elderly, particularly transportation programs. According to a report published by the Department of Transportation in April 1983, on transportation and the elderly, the implications of social and demographic changes on future transportation policy include:

> The demands of the elderly for specialized transportation will increase in the 1980's. This is apparent from the sheer rise in the numbers of older people, and in the expected increased costs of fuel, the increase in costs of purchasing and owning an automobile, and an established and growing demand for mobility among the elderly.
>
> Most of the riders for specialized transportation services are likely to be female, of advanced age, and drawn from minority groups. The economic position of about one-sixth of the aging population, approximately 5 million persons, will constitute the core group who are likely to be transportation disadvantaged, in the full sense of that term, and candidates for specialized transportation services.
>
> Specialized transportation programs will need to consider serving an older, probably less physically able population than heretofore. The marked growth of the 85 years and older population will place increasing demands on the specialized transportation network. That network will need to take into account a group of riders who will have

> some difficulty in walking yet want to maintain a measure of mobility and independence.
>
> Work-oriented trips on the part of the elderly will be on the decrease, both for specialized transportation programs and mass transportation. With diminishing numbers of older persons of both sexes in the labor force, a larger proportion of older people will be seeking trips to more varied destinations other than employment locations.
>
> Accessibility is likely to be an important issue for the elderly, given the expected increase in mobility limitations. Given the high proportion of women who have driven previously, the high incidence of frail eldery, and the greater emphasis on group living and home-delivered services to maintain independence as long as possible, there is likely to be some preference for a combination of personalized specialized accessiblity in contrast to lift-equipped or related conventional transit accessibility. Given the driver licensing characteristics previously described, the emphasis on "auto-like" transportation will be especially dominant among the women who in turn will dominate the age group in terms of numbers. This may also result in increasing conflict between the elderly disabled and the younger disabled for whom "mainstreaming" is an important issue.
>
> It seems quite evident that for the rural elderly over the remainder of the decade of the 1980's and into the 1990's, the need for rural transportation is likely to continue at a higher level than their urban counterparts. Though rural elderly have participated in the migration to the Sunbelt States, it has not been at the same level or rate as the urban elderly. One consequence, is that the rural elderly who remain behind are often the poorest and most vulnerable members of their communities. Their needs will be compounded by lower incomes, lower available public budgets, a more dispersed population, difficulites associated with trip making and by the lack of a developed State or local network even vaguely comparable to urban areas.

In view of increasingly limited Federal participation in transportation services, the role that State and local governments play in this area will become of major significance to needy elderly and handicapped persons. States will need to reassess priorities with attention toward replacing Federal funding through increased State or local taxes or simply eliminating certain services. Although private sector contributions have played a significant role in social service delivery, it is unlikely that this revenue source will be adequate to close the gaps opened by Federal budget cuts in the area of specialized transportation services. Another resource—volunteer activities—has always been important in terms of the provision of transportation services to older Americans. A recent report undertaken for the Administration on Aging on the transportation problems of older Americans indicated that many agencies serving the elderly already use volunteers extensively in their programs. Given the stringency in resources which may be anticipated over the next decade, efforts to increase the role of volunteers are likely to become increasingly important.

The trend toward block grant programs implies a broader range of roles and reinforces the need for advance system planning and priority service setting at the State and local level. Since block grant programs are linked with lower absolute funding levels, the relationship betwen individual State and local governments will need to be better defined if cooperative fiscal efforts by these jurisdictions are to function successfully. Until these relationships are clarified and secured, access by older Americans to the array of community services may continue to be severely hampered.

F. LEGAL SERVICES

Older persons, because of difficulties of access and unique legal problems, have a special need for legal services. This is primarily a result of the low income status of many older persons and the complex nature of the programs upon which the elderly are so dependent. After retirement, most older Americans are dependent upon government-administered benefits and services for their entire income and livelihood. For example, many elderly persons rely on the Social Security Programs for income security and on the Medicare and Medicaid Programs to meet their health needs. These benefit programs are extremely complex and often difficult to understand for persons inexperienced with government.

In addition to governmental benefits, legal problems of older persons typically relate to consumer fraud, property tax exemptions, special property tax assessments, guardianships, involuntary commitment to an institution, nursing home, and probate matters. Legal services and professional legal representation by those who know the law are of vital importance to the elderly because it helps them to obtain basic necessities and assures that they receive benefits and services to which they are entitled and for which they have worked all their lives.

Unfortunately, older persons encounter special problems in gaining access to legal services. A large number of older persons cannot afford to hire a private attorney, particularly those who qualify for many benefit programs. Others are not comfortable accepting free or low cost legal services and others are simply wary of dealing with members of the legal profession. In addition, many older persons may fail to recognize some of their problems as legal problems and may not be aware of existing legal services. Finally, many older Americans face specific barriers to legal services because of lack of transportation, physical handicaps, fear of crime, and difficulty in communication.

1. Federal Programs

In addition to legal services provided by the private bar, a number of existing Federal programs provide legal services for older persons. Programs funded under the social services block grant established under the Omnibus Reconciliation Act of 1981, the Older Americans Act, and the Legal Services Corporation are among these programs. Of these three, the Legal Services Corporation is the largest provider of legal services to low income elderly.

(A) BACKGROUND

(1) The Legal Services Corporation

Legislation creating the Legal Services Corporation [LSC] was enacted in July 1974. Previously, legal services had been a program of the Office of Economic Opportunity, added to the Economic Opportunity Act of 1966. President Nixon, however, recognized that because some of the litigation initiated by legal services brought it in direct conflict with local and State governments and because the program is concerned with social issues, it is subject to unusually strong political pressures. In 1971, in an effort to insulate the program from those political pressures, he requested legislation creating a separate, independently housed corporation. The Legal Services Program was then established as a private, nonprofit corporation headed by an 11-member board of directors, nominated by the President and confirmed by the Senate.

The Corporation does not provide legal services directly; rather, it funds local legal aid projects. Each local legal service project is headed by a board of directors, of which 60 percent are lawyers who have been admitted to a State bar. The Corporation also funds a number of national support centers, which develop and provide specialized expertise in various aspects of poverty law to legal services attorneys in the field.

Legal services provided through Corporation funds are available only in civil matters and to any individual with an income no higher than a set standard which utilizes the Office of Management and Budget poverty guidelines. When the Corporation was established in 1975, its foremost goal was to provide all low-income people with at least "minimum access" to legal services. This was defined as the equivalent of 2 legal services attorneys for every 10,000 poor people. In fiscal year 1980, the goal of minimum access was achieved with an appropriation of $300 million. Currently, however, the LSC is not funded to provide minimum access to legal assistance for poor persons. In most States, only 1 attorney serves 10,000 poor persons, and more than one of the three LSC-funded programs is staffed at levels of less than half of this minimum access standard. To meet the minimum access level now, the National Legal Aid and Defender Association has estimated that the Corporation would need a fiscal year 1985 budget of $470 million.

Several restrictions on the types of cases legal services attorneys may handle were included in the original law and several others have been added since then. Most of the restrictions were made in response to the critics of the program who charge that legal services funds have been used to promote the social and political goals of activist attorneys, in the guise of providing legal assistance to the poor. They believe that although legal services attorneys are theoretically prohibited from pursuing their own political and social interests by a requirement that they must be representing a particular client before getting involved in an issue, this requirement is easily circumvented without specific restrictions. The current restrictions include a prohibition on cases dealing with school desegregation, nontherapeutic abortions, certain violations of the Selective Service Act, and Armed Forces desertion. The appropriations measures currently in effect contains further prohibitions against lobbying with Corporation funds, representing aliens who don't meet specified conditions, and class action suits against Federal, State, or local governments except under certain regulations.

Other restricitons were placed in the regulations by supporters of legal services who were concerned that the broad scope of the Corporation's work would be sharply curtailed. For example, the current appropriations measure prohibits board members who have not been confirmed by the Senate from reducing current grants. One restriction places limits on the amount of pay board members may receive and the type of fringe benefits employees may be given. This restriction stems from a controversy which arose in late 1982 concerning what were thought by some to be unusually excessive consultant and travel fees received by the board of directors. Another restriction prohibits use of funds to issue new regulations or to enforce those effective after April 27, 1984, unless the House and Senate Appropriations Committees have been notified 15 days in advance. This restriction was added in response to concerns that proposed regulations issued by the LSC, such as those curtailing legislative and administrative advocacy by LSC attorneys on behalf of poor clients, would drastically change existing policy within the Corporation.

(2) Current Status of Federal Programs

At the start of 1984, there were 325 legal services programs throughout the 50 States, the District of Columbia, the Virgin Islands, Puerto Rico, Micronesia, and Guam. The number of field program offices at the start of 1984 were 1,367, down from 1,475 in 1981. At the end of 1983, the LSC employed 4,766 attorneys, as compared to 6,559 in 1980. LSC programs handled and closed 1,271,473 cases in fiscal year 1983.

The Corporation places primary emphasis on the provision of routine legal services and the majority of LSC-funded activities involve routine legal problems of low-income people. According to the Corporation's 1984 annual report, almost one-third of legal services cases are family related, such as divorce and separation, child custody and support, and adoption. Another 18 percent of legal services cases deal with housing problems, primarily landlord-tenant disputes in non-Government subsidized housing. Problems with welfare or other income maintenance programs, and consumer and finance problems form the next two largest categories of legal services cases. Most cases (about 90 percent) are resolved outside the courtroom. Of the 1,271,473 cases closed in 1983, only 1,830 class action suits were reported.

Although programs funded under the Legal Services Corporation Act make services available to all low-income persons, persons 60 years of age and older constitute a sizable portion of the client eligible population. Twelve and one-half percent, or 161,478 of the cases handled in 1983 involved a client age 60 and over. This figure represents a decrease over the 1982 level of 14 percent.

At the national level, the LSC has funded a number of national support centers which are involved in issues that confront older people. These include the National Senior Citizens Law Center

[NSCLC], in Los Angeles and Washington, DC; Legal Counsel for the Elderly [LCE], in Washington, DC; and Legal Services for the Elderly [LSE] in New York City.

(B) ISSUES

Almost everyone recognizes that provision of legal services to the elderly is vital. Yet there has been continuing controversy as to how best to provide these services. This dispute was touched off again when President Reagan proposed in 1981 to terminate the federally funded Legal Services Corporation and to include legal services activities in a social services block grant. Funds then going to the Corporation, however, were not proposed for inclusion in the block grant. The block grant approach is consistent with the administration's goal of consolidating categorical grant programs and transferring decisionmaking authority to the States. Inclusion of legal services as an eligible activity in block grants, it was argued, would give States greater flexibility to target funds where the need is greatest and that allowing States to make funding decisions regarding legal services would make the program accountable to elected officials.

President Reagan justified his proposal to terminate the Legal Services Corporation by stating his belief that added pro bono efforts by private attorneys could substantially augment legal services funding provided by the block grant. The administration noted that elimination of restrictions on advertising by attorneys would increase the availability of low-cost legal services. They pointed to a congressionally mandated study which found legal services provided by private attorneys to be as effective as those provided by staff attorneys hired directly by local legal services programs. Their approach would allow States to choose among a variety of service delivery mechanisms, including reimbursement to private attorneys, rather than almost exclusive use of full-time staff attorneys supported by the Corporation. Finally, the administration argued that regardless of the continued existence of the LSC, some funding is available at the State and local level for civil legal assistance to truly needy individuals. Nearly $50 million in funds, they say, is available through the Older Americans Act, under the social services block grant, and from a variety of public and private sources.

Supporters of federally funded legal services programs argue that neither State or local governments nor the private bar would be able to fill the gap in services created by abolition of the LSC. They cite the inherent conflict of interest and the State's traditional nonrole in civil legal services, which, they say, makes it unlikely that States will move forward to provide effective legal services to the poor. Many feel that the voluntary efforts of private attorneys cannot be relied on, especially when more lucrative work beckons. Some feel that, in contrast to the LSC lawyers who have expertise in poverty law, private lawyers are not as likely to have this experience nor are they as likely to have the interest in dealing with the systematic abuses that poor people encounter.

Defenders of LSC say that the need among low-income people for civil legal assistance exceeds the level of services currently provided by both the Corporation and the private bar. Elimination of the Corporation and its funding could further impair the rights of poor people to equal access to justice under the law. They contend that it is also inconsistent to assure low-income people representation in criminal matters, but not to provide them with legal assistance in civil cases.

The broad controversy surrounding the provision of legal assistance to the poor has been played out in the funding, authorization and nomination process for the Legal Services Corporation and can be seen in the history of the Corporation. While the controversy still goes on, it is significant that Congress has consistently opposed President Reagan's proposals to abolish the LSC.

(C) LEGISLATIVE ACTIVITY IN 1984

(1) REAUTHORIZATION AND FUNDING

(a) Legal Services Corporation Act

The LSC Act of 1974 was reauthorized in 1977 for three additional years. At that time much of the controversy surrounding the program, which grew from a perception that the program was one of social activism and reform rather than routine legal assistance for low-income individuals, had abated. Since the early 1980's, however, the controversy as to whether Federal legal aid money is being misused to promote liberal political causes has re-emerged. This is due, in part, to the fact that every year since 1981, the Reagan administration has announced plans not to seek reauthorization of the program and has requested no funding for it. Congress, however, has rejected these proposals and has included LSC in continuing resolutions for fiscal years 1981 through 1985.

Funding for the the LSC in its first year was $92.3 million. It rose to its highest level of $321.3 million in 1981. Since then, however, funding for LSC has been reduced. In fiscal year 1982, funding for the Corporation was cut by 25 percent to $241 million. This level was maintained in 1983. Funding for fiscal year 1984 was increased somewhat from the 1982 and 1983 levels, but still remains below the fiscal year 1981 funding level. $275 million was appropriated for the LSC in 1984 [Public Law 98-107]. For fiscal year 1985, $305 million was appropriated for the LSC [Public Law 98-411]. Provisions in Public Law 98-411 will earmark $2 million for new legal services activities for the elderly.

(b) Social services block grant

Under the block grant program, Federal funds are allocated to States, which in turn provide services directly or contract with public and nonprofit social service agencies for providing social services to persons and families. States, for the most part, determine which social services to provide and for whom they shall be provided. Services may include legal aid. In fiscal year 1984, contributions to the Legal Services Corporation for the provision of legal services totaled more than $9 million. This represents a decrease over the fiscal year 1983 figure of $12 million. Because the Reconciliation Act and the Department of Health and Human Services have eliminated much of the reporting requirements previously included in the title XX program, very little information is available on how States have responded to both funding reductions and changes in the legislation. Thus, there is no information available on the number of persons or the age breakdown of those persons who are being served.

(c) Legal services under the Older Americans Act

Support for legal services under the Older Americans Act [OAA] was a subject of interest to both the Congress and the Administration on Aging [AoA] for several years preceding the 1973 amendments to the OAA. There was no specific reference to legal services in the initial version of the OAA in 1965, but recommendations concerning legal services were among those made at the 1971 White House Conference on Aging. Regulations promulgated by the AoA in 1973, for the first time identified legal services as eligible for funding under title III of the OAA. The amendments to the OAA in 1978, established a funding mechanism and a programmatic structure for legal services. Area agencies on aging are required by the Older Americans Act to allocate an adequate proportion of title III supportive services funds for legal assistance.[1] The 1984 amendments to the act added a requirement that area agencies annually document the amount of funds expended for this assistance. The act also requires that area agencies contract with legal assistance providers which can demonstrate the experience or capacity to deliver legal assistance and to involve the private bar in legal assistance activities. Where the legal assistance grantee is not a Legal Service Corporation grantee, that provider is required to coordinate services with LSC-funded programs in its area.

Unfortunately, the amount of title III funds expended on legal services for fiscal year 1984 is not available. As part of its efforts to reduce State reporting burdens, AoA discontinued the requirement that States report expenditure data on types of services. According to the AoA Fiscal Year 1983 Program Performance Report, however, the total number of persons who received legal services was 474,368 persons.

The OAA requires State agencies on aging to establish and operate a long-term care ombudsman program which, among other things, investigates and resolves complaints made by or on behalf of older residents of long-term care facilities. The 1981 amendments to the OAA expanded the required scope of the ombudsman program to include board and care facilities. In many States and localities, there is a close and mutually supportive relationship between State and local ombudsman programs and legal services programs.

The AoA has stressed the importance of such a relationship and provides grants to States designed to further ombudsman, legal, and protective services activities for older people and to assure coordination of these activities. State ombudsman reports indicate that through both formal and informal agreements, legal services attorneys and paralegals help ombudsmen secure access to facilities, residents, and residents' records; provide consultation to ombudsmen on law and regulations affecting institutionalized persons; represent clients referred by ombudsman programs; and work with ombudsmen and others to bring about changes in policies, laws, and regulations which benefit older persons in institutions.

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[1] The 1984 amendments to the Older Americans Act, Public Law 98-459, substituted the term "legal assistance" for "legal services."

The AoA has allocated the bulk of OAA title IV funds earmarked for legal services for grants to State agencies on aging for "legal service developers." These State legal services development grants have served to support and coordinate publicly and privately provided legal services for older persons in that State. State responses to this provision, however, have been irregular, and many States now have vacancies in this position.

In fiscal year 1984, AoA awarded $2,862,200 to support State legal, ombudsman, and protective service activities. This funding supports a variety of activities associated with protective and long-term-care ombudsman services as well as legal services. In addition to the State awards, AoA awarded title IV funds to support legal services activities by other organizations. The American Bar Association was awarded $192,603 to conduct a project entitled the national bar activation for the elderly project. The project is designed to increase private sector involvement in the delivery of legal services to the elderly. In addition, the ABA is conducting another project under a $100,000 award, entitled home equity conversions: enhancing legal awareness. The project is designed to coordinate legal analysis in the home equity conversion field and increase the awareness of the legal aspects of home equity conversion by the private bar and other segments of the legal community. The American Association of Retired Persons received an award of $101,173 for a project entitled free legal hot line. The purpose of the project is to determine whether a free, citywide legal hot line for older people can be self-supporting using an innovative financial scheme.

(2) Legal Services Corporation Board of Directors

During the summer of 1981, the appointments of all 11 LSC board members appointed by former President Carter had expired. President Reagan, however, did not appoint new members of the board until December 1981, after it became apparent that his proposal to terminate the Corporation would not be accepted. Since then he has appointed a succession of 19 people to the board on an interim basis. Because these appointments were made while Congress was in recess, they could serve without any Senate confirmation. Some of the recess appointees have come under fire because of their alleged hostility to the LSC program and its goals. For this reason, the Senate has placed restrictions on the powers of unconfirmed recess appointees. For example, a key appropriations rider limits the authority of unconfirmed board members to cut or reduce grants to disfavored legal aid programs.

Since 1982, President Reagan has announced 25 prospective nominees, but none have been confirmed by the Senate. Some of them have been opposed by liberals and moderates who have questioned their qualifications and their commitment to legal services for the poor. The Senate took no action in 1982 on the first group of nominees because of the ongoing controversy surrounding recess appointees who were perceived as opponents of the LSC and who did not gain approval of the Labor and Human Resources Committee. Reports in 1982 that LSC board members were receiving extraordinarily large consulting fees for their services and that the LSC president was given unusually generous fringe benefits further affected the nomination process. Subsequent investigations by the Office of Management and Budget and the General Accounting Office, however, cleared the board members of any wrongdoing. Attempts to confirm individuals nominated by President Reagan in 1983 also failed because the committee lacked a quorum at its meetings. When Congress adjourned for the year, nominations lapsed. On March 19, 1984, President Reagan again submitted all 11 nominations for Senate consideration. The Senate Labor and Human Resources Committee reported 10 of these nominees favorably to the full Senate on May 2, 1984. The last nominee was not approved by the committee. Instead, the committee voted to send his name to the Senate without recommendation. The full Senate did not take action on these nominations before it adjourned in October 1984.

Because the President's nominees were not confirmed during the congressional session, President Reagan made these individuals "recess" appointees to the LSC board. They will be able to serve through the next congressional session unless specifically rejected on a Senate vote. Some opine that President Reagan took this route since there is doubt that the nominees would win Senate approval and that the confirmation process would be lengthy. The board, however, is limited in the work that it will be able to perform, since various restrictions on their activities are included in the appropriations bill for the LSC.

2. PRIVATE BAR

An essential component of legal services delivery systems for the elderly is the private bar. The expertise of the private bar is considered especially important in such areas as wills and estates, real estate and tax planning. Although many have cited the capacity of the private bar to meet some of the legal needs of the elderly on a full-fee, low-fee, or no-fee (pro bono) basis, the potential of the private bar to serve the elderly in need of legal assistance has not yet been fully realized. Efforts to encourage private bar involvement, however, are well underway.

To counter the effects of cuts in Federal legal services and to ease the pressure on overburdened legal services agencies, some law firms and corporate legal departments have begun to devote more of their time to the poor on a pro bono basis. These programs are in conformity with the lawyer's code of professional responsibility which requires every lawyer to support the provision of legal services to the disadvantaged. While such programs are gaining momentum, there is no precise way to determine the actual number of lawyers involved in the volunteer work, the number of hours donated, and the number of clients served. Most lawyers for the poor say that these efforts are not yet enough to fill the gap and that a more intensive organized effort is needed to motivate and find volunteer attorneys. This assessment is noteworthy in light of the fact that President Reagan has justified his desire to abolish the LSC by saying that legal services for the poor could be provided more efficiently by members of the private bar.

Another development in the delivery of legal services by the private bar has been the introduction in the United States of the IOLTA [Interest on Lawyers' Trust Accounts] program. This program allows attorneys to pool client trust deposits in interest bearing accounts. The interest generated from these accounts is then channeled into federally funded, bar affiliated, and private and nonprofit providers of legal services. Thirty-nine States have already adopted some form of IOLTA and a reported $20 million has already been raised through this program across the country. An American Bar Association study group estimated that if the plan was adopted on a nationwide basis, it could produce up to $100 million a year. Supporters of the concept believe that there is no cost to anyone with the exception of banks, which participate voluntarily. Critics of the plan contend that it is an unconstitutional misuse of the money of a paying client who is not ordinarily apprised of how the money is spent. While there is no unanimity at this time among lawyers regarding IOLTA, it appears to have potential value as a needed funding alternative.

As recognized by the American Bar Association, private bar efforts alone fall far short in providing for the needs of older Americans for legal help. They have consistently maintained that the most effective approach for providing adequate legal representation and advice for needy older persons is through the combined efforts of a countinuing Legal Services Corporation, an effective Older Americans Act program, and the private bar. With increased emphasis on private bar involvement, and with the necessity of leveraging resources, the opportunity to design more comprehensive legal service programs for the elderly exists.

In 1977, the then-president of the American Bar Association was determined to add the concerns of senior citizens to the ABA's roster of public service priorities. He designated a task force to examine the status of legal problems and the needs confronting the elderly and to determine what role the ABA could play. Based on a recommendation of the task force, an interdisciplinary Commission on Legal Problems of the Elderly was established by the American Bar Association in 1978. The commission was charged with examining four priority areas—provision of legal services to the elderly, discrimination against the elderly, simplification and coordination of administrative procedures and regulations, and issues involving long-term care. Subsequently, two new priority areas were added: Housing and Social Security. The commission has undertaken many activities to promote the development of legal resources for older persons and to involve the private bar in responding to the needs of the aged.

One such activity is the national bar activation project which provides technical assistance to State and local bar associations, law firms, corporate counsel, legal service projects, the aging network, and others in developing projects for older persons. It aims to generate pro bono, reduced-fee referral, and community education programs for senior citizens, as well as relevant continuing legal education curriculums for attorneys. In addition, the project publishes a quarterly newsletter, Bifocal; acts as a clearinghouse for private bar activities to assist the elderly; and seeks to implement models which afford maximum cooperation among legal services projects, the private bar, and the Older Americans Act network of State and area agencies on aging.

Another significant project begun a couple of years ago, was recently completed by the commission. In October 1982, the Commission on Legal Problems of the Elderly and Commission on the Mentally Disabled were awarded a grant by the U.S. Department of Health and Human Services, Office of Human Development Services, to develop a model act for regulating board and care homes. The goal of the project was to develop a comprehensive and workable statutory scheme for licensing board and care homes to ensure that their elderly and disabled residents enjoy a safe and decent living environment. The final draft of the act, entitled "A Model Act Regulating Board and Care Homes: Guidelines for States," was issued in 1984 and is intended to serve as a model for State legislators undertaking revision of their board and care home licensing programs.

In addition to the commission, the ABA Section on Real Property, Private and Trust Law has a committee on legal problems of the aging. The ABA Young Lawyers Division established a committee on the delivery of legal services to the elderly in 1976. The committee has been active in giving technical assistance to affiliate groups throughout the country.

In supplementation of the activities of the national bar association, State and local bar associations have begun to assist the elderly as well. Over half the State bar associations have committees on the elderly. Many State bars have presented law and aging continuing legal education sessions for lawyers, and a substantial number of bar-sponsored projects for the aged are operating throughout the country. In a 1983 survey, the ABA Division of Bar Services asked 179 bars whether they had a program to address the needs of the elderly. A total of 77 answered that they did.

An August 1984 report entitled "Legal Services for the Elderly: Where the Nation Stands," summed up, as follows:

> In the mideighties, it is fair to say that the organized bar of the legal profession has yet to realize its potential for assistance to our elderly population. The challenge is one that affects us all, not only at the immediate contact point of advanced age, but in shaping and defining the quality of life, the principal of equity, and the values that drive our whole society.

3. Prognosis

The national population segment from which the need for elderly services arises is large and growing. The AoA and the LSC reporting system count older persons on the basis of those over the age of 60. Over 36 million Americans were over 60 in 1982, or roughly 16 percent of the population. Persons over 60 constitute 14.6 percent of all persons below the official Government poverty line. This is approximately 5 million persons. Under 1983 eligibility requirements, individuals with incomes up to 125 percent of the poverty line may be eligible for LSC funded legal assistance. Using this standard, approximately 8.7 million persons over the age of 60 are LSC eligible persons.

Unfortunately, there is no precise way of determining eligibility for legal services under the Older Americans Act since eligibility is based both upon economic and social need, and means testing for eligibility is prohibited. An expert in the field has stated that if one were to consider the potential clientele for Older Americans Act legal services as those realistically unable to afford legal assistance, a majority of older persons would qualify for such assistance. Fully two-thirds of persons over 65 in 1980 had incomes of less than $8,000 per year. Of older persons over 65 and living alone, more than 60 percent had annual incomes of less than $5,000 a year, and 75 percent had annual incomes of less than $7,000. It is clear that a substantial percentage of older persons are poor or near poor and would find it difficult to purchase legal representation.

The availability of legal representation for low-income older persons is determined, in part, by the availability of funding for legal services programs. Given the trend in recent years to cut back the flow of Federal dollars from both AoA and LSC to local programs for delivery of elderly legal services there is no doubt that older persons are finding it more difficult to obtain legal assistance. Since 1981, Congress has reduced funding to the LSC by 25 percent. This funding reduction translates in the loss of 1,793 and the closing of more than 108 local offices, making it more difficult for older persons with legal needs to gain access to legal representation.

The Washington Council of Lawyers, a voluntary, nonpartisan bar association, conducted a survey in the spring of 1983, to measure the impact of the 25-percent reduction in Federal funding for the LSC on the quality and scope of legal representation to the poor. Sixty-one programs, representing 20 percent of all field programs and serving 45 percent of the total eligible client population in the United States, responded to the survey questionnaire. Results of the study were published in a report entitled, "Report on the Status of Legal Services for the Poor," issued in November 1983.

According to this report, the average overall loss in funding for all programs surveyed was 25.6 percent, and the average inflation-adjusted loss in funding was 29.7 percent. A majority of programs reported they failed in their attempts to replace any of the lost Federal funds through State, local, or private sources. Overall, programs lost almost one-third of their staff attorneys and efforts to replace attorneys were substantially impaired by uncertainties as to future funding. Cuts in funding coincided with a national economic recession creating a category of "new poor" and changes in Federal programs creating new legal needs for the poor.

The authors concluded that the population eligible for legal services increased 14.5 percent, from 40.6 million individuals in 1980 to 46.5 million in 1982. Programs surveyed reported that more than one-third of the full- and part-time offices operated by the surveyed programs in 1981 had been closed, reduced in size, or merged into other offices in 1983. In both urban and rural areas, the report noted, clients no longer served because of office closings have had significant difficulty obtaining legal assistance.

Program responses indicated that the private bar, though responsive in many cases, has not been able to fill the gap. Program caseloads were lower in four out of five programs in 1983, largely as a result of a lack of sufficient staff to handle the demand. Most of the programs reported having to turn away more than 500 poor people without providing any legal representation, and 27 programs each turned away over 2,000 poor people without providing any advice or legal representation. In addition, as a result of the funding cuts, field programs were forced to eliminate specialized units, such as elderly units, and to curtail State and local training programs. The report stated that the results of the survey showed a decrease in the ability of the LSC grantees to provide full professional representation to eligible clients in 1983.

In the spring of 1984, the Council resurveyed the 61 programs to determine whether the capacity of the programs to represent poor people had increased in 1983 and early 1984 and whether the findings of the 1983 report were still valid.

Interim results of the resurvey, based on participation of 45 programs, are contained in a statement submitted to the Senate Appropriations Committee on June 11, 1984. According to the statement, funding continues to be a major obstacle to fulfilling the congressional mandate to provide attorneys to eligible clients. Less than a third of the responding programs had more non-LSC funds in 1983 than in 1982 and of these, only 11 (24 percent) replaced 10 percent or more of the lost LSC funding. Only one of the 45 respondents indicated that it had managed to replace more than 50 percent of the LSC funding cuts experienced from 1981 to 1983. Even the 1984 increase in funding leaves the programs well below the level of funding prior to the 25 percent cut.

In addition, while some programs gained additional staff attorneys in 1983, more programs lost attorneys than gained. Finally, programs which experienced widespread closings in 1983 had to cut back even further; none of the programs opened or reopened full- or part-time offices. The statement concludes that the result of underfunding has been an even further decrease in the program's ability to meet their clients' legal needs. More than three-fourths of the responding programs stated that the level of unmet legal needs was greater than it had been in 1982. Only 13 percent of the programs believed that they met a greater amount of legal need in 1983 than in 1982.

The need for civil legal services for the elderly, especially the poor elderly, is undeniable. Many elderly persons, however, cannot obtain legal services because they cannot afford to pay customary legal fees. In addition, a substantial portion of the legal problems of the elderly stems from their dependence on public benefit programs. The private bar is generally unable to undertake representation in these matters because it requires familiarity with a complex body of law and regulations with little chance of generating a fee for services rendered.

It is a basic tenet in our society that those who live under the laws should also have an opportunity to use the law. Access to the legal system for all persons is basic to our democratic system of government and the fundamental purpose of the Legal Services Corporation Act. The federally funded legal services program represents a significant improvement in the system of dispensing justice in this country and has gone a long way to alleviate the harsh consequences of being poor and unable to afford legal services. Yet reductions in funding have caused serious cutbacks of existing programs. If we are to continue to make progress in the goal of equal justice and access for all, the continued funding of legal services by the Federal Government and the strengthened efforts of the private bar will be necessary.

Chapter 13

PERSONAL SAFETY AND CONSUMER ISSUES

OVERVIEW

Old age often increases an individual's vulnerability. The personal safety of the elderly can be particularly threatened by intentional criminal attacks, accidental fires in the homes, and exposure to unsafe or defective consumer products.

The fear of criminal victimization is a matter of serious concern to elderly persons. Recent evidence suggests that, especially in major cities, assaults and purse snatchings directed against older Americans are increasing, and the fear of criminal attack is likewise escalating. Fear of crime can severely limit the opportunities and lifestyles of the more physically vulnerable elderly.

Home fires pose an equally serious threat to the personal safety of older persons. They are more likely to be killed in home fires than younger persons. One-third of all fire deaths are the result of fires started by cigarettes—far more than any other single cause. Prior to 1984, the risk of deaths from cigarette-caused home fires had not been adequately addressed.

The elderly also represent a significant percentage of the consumers harmed each year by essential products and services. Much of this is accidental, but the elderly as a group are especially vulnerable to consumer frauds and deceptions.

The following pages of this chapter discuss various personal safety and consumer issues that received attention and were the subject of local, State, and Federal efforts and activities during 1984.

A. CRIME AND THE ELDERLY

1. Issues

Although the crime rate in the United States has dropped in the last 2 years, it is still substantially higher than it was a decade ago. Statistics demonstrate that crime continues to be a problem of significant magnitude in this country. In 1983, according to the FBI's Uniform Crime Report, a violent crime occurred every 26 seconds in this country. In 1983 alone, more than 37 million Americans were criminally victimized.

(A) ELDERLY VICTIMS

Because of the great incidence and the widespread nature of crime in our country, there has naturally been a growing concern about the fear of crime and the impact of crime upon the elderly. There is good cause for concern. The U.S. Department of Justice estimated that of the 26 million older Americans in this country in 1983, about 182,000 will be the victim of a violent crime, about 642,000 will suffer a theft and 1.3 million elderly households will be burglarized.

These statistics, however, tell only a part of the total story of the crime problem faced by our Nation's elderly. To give the full picture, the special conditions inherent in the aging process that increase the elderly's vulnerability to criminal victimization must be understood. Many of these conditions were identified at hearings conducted by the Senate Special Committee on Aging. The first, entitled "Older Americans: Fighting the Fear of Crime," was held on September 22, 1981, and the second, "Crime Against the Elderly," was held on July 6, 1983. The focus of these hearings was on the impact of crime and fear of crime on the lives of senior citizens and on constructive countermeasures that could be taken to prevent crime and to help crime victims.

Testimony received at the hearings established that the elderly are easy prey for criminals. About 60 percent live in urban areas, where there are more likely to be criminal elements active. Often, the elderly live in social isolation, making them easy targets. Because walking or mass transportation may be their only mode of transportation, they may be present on the streets as easy prey. Advanced age and its accompanying physical frailty also makes the elderly more vulnerable to attack. Too often, they are unable to offer a defense to their attackers.

Crime ranks as the No. 1 concern for many older Americans, according to public opinion polls; 80 percent of the elderly complain that they live in constant fear of crime. This fear of crime affects the quality of life of the elderly. Many seniors change their behavior out of fear of being victimized. They often limit their travel to avoid specific areas and restrict shopping activities to safe times. As a result, they experience even greater social isolation.

Some have questioned whether this extreme fear of crime by the elderly is rational in light of the actual relationship between age and victimization. These individuals cite studies which show that older persons have the lowest overall victimization rate and the lowest crime specific rates of all age groups. They point to studies which show that with the exception of cases of purse-snatching and pocket-picking, the older the individual, the less his or her chances of becoming the victim of a personal crime.

While previous research has also indicated that fear is related inversely to objective risks of victimization, a 1984 study[1] which examined the relation among population groups between victimization rates and fear of crime concluded that for most population groups there is a high degree of correspondence between victimization rates adjusted for exposure to risk and fear of crime. According to the authors, the implication of this study is that fear of crime should not be viewed cavalierly as irrational or unjustified and that even where the correspondence is low (older white females) it is premature to conclude that fear is irrational, for little is known about how objective risks are translated into fear. What is clear, however, is that one reason for the fear is the severe consequences that the elderly person faces if he or she becomes a victim of crime.

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[1] Stafford, "Victimization Rates, Exposure to Risk and Fear of Crime," Criminology, vol. 22, No. 2, May 1984, 173-185.

When older persons do fall victim to crime, the impact on their lives is likely to be greater than on other population groups. They are more likely to be injured, take longer to recover, and incur greater proportional losses to income. Elderly persons are more likely than their younger counterparts to suffer disabling injuries, such as fractured hips or broken bones, because of the physical effects of aging. Injuries may result in long-term hospitalization or even death due to decreased healing capabilities. Because a high proportion of the elderly live on very limited or fixed incomes that cover no more than their basic necessities, the theft of a purse or a Social Security check can be a tremendous hardship. They may have to go without food, medicine, or may fail to make a rent payment. Emotionally, crime victimization of the elderly can be particularly traumatic. All ages are victimized, but such victimizing action has a particularly devastating effect on older Americans.

All victims of crime, regardless of age, suffer twice—first at the hands of the assailant and then by the treatment they face after the crime, mostly at the hands of law-enforcement officials throughout the criminal process. The delays, financial loss, lost work time, and lack of consideration all contribute to a feeling of disenchantment, not only with the offender, but also with the criminal justice system.

In the past, little attention was paid to the rights and concerns of victims of crime—rather, the attention was focused primarily on the rights of criminal offenders. Recently, however, there has been a growing public awareness of the financial, physical, and psychological trauma suffered by crime victims. As public concern for victims of crime has grown, law enforcement and other government officials have begun to recognize that it is important to improve victim attitudes and treatment, not only for humanitarian reasons, but also to ensure that victims continue to participate and cooperate with law enforcement officials in pursuing cases. This awareness and concern for victims has led to State and Federal efforts to respond to the problems of crime victims.

(B) STATE VICTIMS COMPENSATION

At the State level, victims compensation programs have been established in 39 States to restore losses to victims. The basic purpose of victims compensation programs is to provide financial help to innocent victims who are injured in violent crimes. The financial assistance is generally provided to cover a victim's unreimbursed medical expenses and losses of earnings that occur because of criminal injury or to provide survivor's benefits for the dependents of certain homicide victims. State victim compensation programs receive funding from several sources: Almost 40 percent of the State programs are funded solely through general revenues; about 36 percent are funded solely through fines and penalty mechanisms; and the rest through a combination of general revenues and fines and penalties.

Virtually all of these State crime victim's compensation programs, however, are experiencing financial problems. As a result, many States are being forced to limit the amount of their awards. Others do not advertise program availability for fear of depleting available resources or overtaxing numerically inadequate staff. In addition, because of funding problems in many States, victims may have to wait months before the compensation claim can be processed or sufficient revenue is generated to pay the claim.

A 1983 analysis of American compensation programs by the Center for Criminal Justice, Harvard Law School, which surveyed 30 State programs, found that they had made payments totaling almost $50 million to victims. The range of total payments to victims among the States varied widely—one State paid out as little as $7,427, while another State paid out more than $15 million. Sixty-eight percent of the State programs had awards of less than $3,000 and only three States had an average award of over $5,000. One expert has suggested that if victim assistance could involve compensation for all losses attributable to crime, that assistance would require approximately 7 percent of the American gross national product.

Unfortunately, very little information is available regarding the impact of compensation programs on victim's economic or psychological well-being and there is a clear need for research in this area. While crime victim service programs are providing valuable assistance to thousands of elderly crime victims, due to legal restrictions, inadequate funding, and general lack of public awareness, they are reaching only a small fraction of the Nation's elderly crime victims. According to Ronald Zweibel, president of the National Association of Victim's Compensation Programs, of the 60,000 elderly violent crime victims eligible for an award for compensable loss in 1983, only 4,000 were expected to receive any compensation. Thus, a large elderly crime victim population is not receiving needed assistance from the present compensation system.

In addition to State compensation programs, there are about 400 local victim assistance programs throughout the country. These programs offer a wide array of services such as emergency shelter, advocacy and referral, counseling and victim/witness information and protection. Twenty-four percent of all the victims served by these assistance programs are elderly. While these programs complement the assistance available from the compensation programs, a large majority of the elderly victim population are still not being served.

(C) THE FEDERAL ROLE

At the Federal level, the President's Task Force on Victim's of Crime, established by President Reagan in 1982, issued a comprehensive report on the status of victims with recommendations for the improved treatment of victims by the criminal justice system in early 1983. The task force concluded that the treatment of victims by the criminal justice system has been careless and shameful. In many cases, the criminal received more consideration and fairer treatment than the victim. In the words of the task force:

> Innocent victims of crime have been overlooked, their pleas for justice have gone unheeded, and their wounds—personal, emotional, and financial—have gone unattended.

Though the recommendations issued by the task force did not focus on the specific problems of the elderly, the implications of their recommendations on the elderly are significant.

One of the principal recommendations of the task force was a request for congressional action in enacting legislation to provide Federal funding to assist State crime victim compensation programs. The task force recommended that a crime victim's assistance fund be created and that it rely in part on Federal criminal fines, penalties, and forfeitures that currently are paid directly into the general fund. This recommendation reflects the concept that it is appropriate that criminals compensate their victims to the extent possible. This approach also insures that the program established would be administratively self-sufficient.

The second basic recommendation of the task force dealt with the establishment of victim/witness assistance units. The task force recommended that Congress enact legislation to provide Federal funding, reasonably matched by local revenues, to assist in the operation of Federal, State, local, and private victim/witness agencies. The express view of the task force was that although the Federal Government should not fully subsidize these agencies, their efforts should be encouraged by financial assistance.

The Assistant Attorney General and former chairman of the President's task force, Lois H. Herrington, stated publicly in September 1983, that the proposal of such legislation was under serious and careful consideration within the Department of Justice.

2. Legislative Initiatives

(A) VICTIMS COMPENSATION

Spurred on by a strong victims' rights movement, there has been considerable interest in Congress in victim's compensation over the last two decades. With the exception, however, of the Victim and Witness Protection Act of 1982, which contains a wide variety of reforms designed to address the urgent problems suffered by crime victims, no other major victims' compensation legislation was enacted until 1984.

On October 12, 1982, the President signed into law the 1982 Victims and Witness Protection Act, legislation which Senators Heinz and Laxalt introduced in April 1982. This was the first piece of victims' rights legislation ever to pass Congress. The law broke new ground in many areas. It institutes the use of victim impact statements so that judges hearing Federal cases will be apprised prior to sentencing an offender of the harm caused to the victim. Restitution for losses incurred by a victim, such as medical bills or replacement of stolen or damaged property, is made a requirement of the sentence. If the judge decides that restitution is unnecessary, his reasoning is required to become a part of the record. The law expands the Attorney General's powers to protect both victims and witnesses from intimidation and harassment and establishes guidelines for the fair treatment of victims and witnesses. For example, victims must be informed as to the progress of a case and prosecutors must consult with victims before entering into plea bargains or dismissals.

While restitution is an important and vital service, it is limited and reaches only a small portion of the victim population. Since less than 20 percent of all crimes lead to an arrest, less than 10 percent of the accused are ever prosecuted and less than 3 percent of those arrested are actually convicted, 97 percent of all victims would go unaided if restitution were their only means of assistance. Even in successful cases, restitution is not a complete remedy because the criminal does not always have the resources to provide relief if restitution is ordered.

Because of the limits of restitution, legislators recognized the need for a fund into which fines levied against all persons convicted of their crimes would be deposited. A number of bills to establish a crime victims assistance fund were introduced in the 98th Congress. Among the bills was S. 704, the Crime Victims Assistance Act, introduced by Senators Heinz and Grassley on March 8, 1983, to provide financial support for State victims' compensation programs and for Federal and State victims' and witness assistance programs. On June 28, 1983, Senator Grassley chaired a hearing of the Subcommittee on Aging, Labor and Human Resources Committee, entitled "Crime and the Elderly: Does Victim Compensation Work" at which Senator Heinz testified on the urgent need for Federal Government assistance to ensure the availability of adequate funds to support compensation programs.

A major breakthrough occurred in 1984 when, for the first time, a victims' compensation and assistance bill was sent to Congress by the President. On March 6, 1984, Attorney General William French Smith proposed a crime victims bill with provisions implementing many of the recommendations made by President Reagan's Task Force on Victims of Crime. Under the administration's proposal, the Federal Government would provide money to the States to enable them to effectively run their own programs, with the States continuing to make their own policy decisions.

The administration proposal was introduced on March 13, 1984, by Senate Judiciary Committee Chairman Strom Thurmond as S. 2423, the Victims of Crime Assistance Act of 1984. On May 1, 1984, the Judiciary Committee held a hearing on S. 2423. Senator John Heinz, an original cosponsor of the bill, testified before the committee on the complex issue of the revenue collection provisions of the bill. Other witnesses testifying at both hearings were unanimous in their strong support for legislation providing Federal financial assistance to State compensation and assistance programs, and better coordination and financing of victim assistance efforts on the Federal level.

On May 25 the Committee on the Judiciary reported S. 2423 with amendments which incorporated many of the changes recommended by witnesses at the May 1 hearing. S. 2423, the "Victims of Crime Act of 1984," passed the Senate August 10. It was agreed to as amended by both Chambers as part of a continuing resolution for appropriations for fiscal year 1985 on October 10; (H.J. Res. 648) and was signed into law by the President on Octobert 12, 1984.

The act creates a crime victims fund in the U.S. Department of Treasury, financed through fines collected from persons convicted of Federal offenses, plus forfeited bonds and collateral. It authorizes grants from the Fund to existing State victim compensation programs which offer compensation to victims or their survivors for medical expenses, loss of wages, and funeral expenses. It also authorizes grants to States for victim assistance programs run by public agencies or nonprofit organizations. Under the act, Federal courts, upon the request of a U.S. attorney, can prevent an individual convicted of a crime causing physical harm from profiting from that crime by ordering forfeiture of proceeds from depiction of the crime in a movie, book, newspaper, magazine, drama, radio, or television production. A Federal judge can order the person who contracted with the defendant to pay the specified amount to the Attorney General. These proceeds are held in the fund for 5 years, with allowance for payment for certain purposes. After 5 years, the court may require all or a part of the proceeds to be released for use by the fund. Under the act, a victim is permitted to make a statement (oral or otherwise) at parole proceedings about the financial, social, psychological, and emotional loss or harm he or she has suffered. The act also provides appointment by the Attorney General of an official of the Department of Justice to be the Federal Crime Victim Assistance Administrator to monitor compliance for the fair treatment of crime victims and witnesses, to consult with Federal law enforcement agencies, and to coordinate victim services provided by the Federal Government with those provided by public and private agencies.

The Federal and State governments have a strong interest in recognizing crime victims as integral components of the criminal justice system. That system could not function successfully without the full cooperation and participation of victims. Until recently, however, the criminal justice system had largely ignored the traumatic impact of crime upon victims. State and local governments were the first to respond by developing victim compensation programs, which have spread across the Nation. Due to a lack in funding, however, the State victim compensation programs have experienced problems. The Victims of Crime Act of 1984 represents a step toward providing sufficient funds to State programs so that they can begin to fulfill their goals of compensating and assisting the innocent victims of crime in a more expeditious and effective manner. It is also hoped that the new law will contribute to a reduction of crime, as crime victims become more willing to report crime and cooperate in the prosecution of criminals.

(B) DOMESTIC VIOLENCE

Violence within the family is a serious problem in the United States. It can be directed at children, at spouses, or at elderly family members and can adversely affect the entire household. Family members are often extremely reluctant to report such conduct out of fear, loyalty, love, and shame. They often do not want their attacker prosecuted, they only want the violence to stop and to try to preserve family life. Because the causes of and solution to domestic violence are extremely complex, it is deserving of special attention. Only recently, however, has the problem of domestic violence come out from behind closed doors to receive this necessary attention. In recognition of the seriousness of the domestic violence problem, numerous bills were introduced during the 98th Congress which were designed to prevent domestic violence and to provide immediate shelter and other assistance for victims of domestic violence and their dependents. Congressional activity in this area culminated in passage of the Family Violence and Services Act, signed into law on October 9, 1984 (Public Law 98-457). This act contains several provisions which relate to elderly victims of domestic violence and to elder abuse.

The purpose of the act is to demonstrate the effectiveness of assisting States in efforts to prevent family violence and to provide shelter and related assistance for victims and technical assistance and training to States, local public agencies and nonprofit organizations.

The act requires the Secretary to coordinate with the Administration on Aging and the National Institute on Aging on all activities involving prevention of family violence and assistance to victims of family violence as they relate to elderly persons. In addition, it provides that the Secretary conduct research into the causes, prevention, identification, and treatment of family violence, including the necessity and impact of mandatory reporting requirements on incidents of family violence, particularly abuse of elderly persons. The Secretary is also required to make a complete study and investigation (in consultation with the National Institute on Aging) of the national incidence of abuse, neglect, and exploitation of elderly persons, including a determination of the extent to which such incidents are increasing in number and severity. Finally, the act creates a national clearinghouse to collect, analyze, and disseminate information on family and elder abuse.

In a related vein, the Older Americans Act Amendments of 1984, enacted on October 9, 1984 [Public Law 98-459], makes the prevention of elder abuse a permissive service under the area plans and requires area agencies to assess the need for elder abuse services and the extent to which such need is being met. Based on the information gathered by the area agencies, and within 2 years, the Commissioner of the Administration on Aging is to report to Congress on the extent to which the need for abuse prevention services are not being met.

3. CONCLUSION

The crime victim and domestic violence legislation enacted in 1984 is an expression of the growing public concern for victims of crime over the last decade. Today's 26 million elderly in the United States—about 11 percent of the population—will grow to be some 17 percent of the population by the year 2000. This major shift in the age structure of our population is likely to bring about profound changes in the future pattern of crime. While we don't yet know what these changes will be, we must recognize that we are clearly facing a problem of seriously growing dimensions for the elderly. As a nation, it will be necessary to continue to work to reduce the rate of crime in the country and to continue efforts to provide assistance and protection to those who have suffered at the hands of criminals.

B. CONSUMER PROTECTION

The population aged 65 and older is a lucrative source of consumer expenditures—worth well over $60 billion annually. The fact that older Americans represent such a large source of consumer expenditures, combined with a number of age-related factors, contribute to making the elderly the easiest targets for consumer frauds and deceptions. For example, because the elderly often live on fixed incomes, are more prone to chronic health conditions, and have less mobility than other consumers, they are particularly vulnerable to unlawful and deceptive trade practices. This is especially true in the health care area, where older Americans spend almost three times as much per capita as do other adults.

While older Americans as a cumulative market are gaining in consumer power, as individuals, many live close to the poverty line and have little in the way of disposable income. Consequently, crimes aimed at the pocketbooks of the elderly often have severe consequences for their victims. Basic consumer protection—preventing fraud, insuring truthful advertising, and requiring that businesses keep their promises—is of particular importance to the elderly.

The elderly also represent a significant percentage of consumers who are harmed each year by essential products and services. For example, people over 65 were hospitalized for product-related injuries in the United States during 1983 at a much higher proportion (20 percent) than the population as a whole (4 percent). Injuries associated with stairs, steps, floors or flooring materials were suffered most frequently by the elderly. Older Americans are also more likely to be victims of home fire deaths. And the elderly make up 60 percent of the victims of health care quackery.

In recognition of their unique vulnerability, older consumers have received a great deal of public attention through actions of Federal administrative agencies and the Congress. During 1984, a number of valuable programs and legislative measures were initiated to help reduce the risks of injury faced by the elderly and to provide basic consumer protection. Major activity has taken place in the areas of home fires, medical technology and devices, medical quackery and patient protection, drugs, banking, deceptive practices, and telecommunications.

1. Home Fire Deaths

In 1984, attention was focused on the serious problem of home fires in this country, and legislation was passed to reduce the risk of injury and death cause by such fires.

(A) ISSUES

Each year, 750,000 home fires occur in the United States, resulting in 6,000 deaths, This threat is especially serious to our Nation's 29 million senior citizens. Older persons are two to three times more likely than younger individuals to be victims of home fires.

One-third of all fire deaths are the result of fires started by cigarettes—far more than any other single cause. Cigarettes cause almost 2,000 residential fire deaths annually in the United States. Cigarette fires also cause approximately 3,800 annual reportable injuries, over $300 million in annual property loss, thousands of dollars in medical costs, and significant losses in productivity.

Many of these deaths are preventable. Given the disproportionately high fire death rate of older Americans when compared to other age groups, greater home fire safety precautions are necessary for our senior citizens. To explore the problem of older Americans dying in home fires, the Senate Special Committee on Aging held a hearing on July 28, 1983, entitled "Home Fire Deaths: A Preventable Tragedy." The purpose of the hearing was to explore the appropriate Federal role in reducing the loss of lives, especially those of the elderly, in home fires.

(B) LEGISLATIVE ACTIVITY

As a result of the findings of the hearing, Senators Heinz, Danforth, and Cranston introduced S. 1935, the Cigarette Safety Study Act, in October 1983, to establish a Federal interagency task force to study the technical and economic feasibility of developing a fire-safe cigarette—a cigarette with a reduced propensity to ignite home furnishings. In the House, H.R. 1880 was introduced by Representative Moakley to authorize the Consumer Product Safety Commission to set performance standards insuring that cigarettes and little cigars do not ignite smoldering upholstered furniture and mattress fires. Congressional sponsors of the cigarette safety legislation saw a major breakthrough in 1984 when the Tobacco Institute, the trade association of tobacco product manufacturers, abandoned their longstanding opposition to fire-safe cigarette legislation and endorsed a compromise proposal.

The compromise calls for an inter-Government agency review of the cigarette fire issue with the assistance of the tobacco industry, the fire service, the medical community, and the furniture industry. Under the legislation, a technical study will be completed and submitted to Congress with recommendations on questions concerning product modification and health consequences.

Supporters of Federal fire-safe cigarette legislation have long argued that altering the physical characteristics of commercial cigarettes may lead to significant reductions in the high number of fire fatalities which occur annually in the United States. Senator Heinz hailed the signing of the legislation into law, in October 1984, as one of special importance for senior citizens, who are the most likely victims in home fires caused by cigarettes.

2. Medical Technology and Devices

Major efforts to reform the regulation of medical devices came to fruition in 1984. Many of these efforts were a response to a May 1983 report of the House Energy and Commerce Subcommittee on Oversight and Investigation which concluded that the Food and Drug Administration [FDA] had not made a meaningful effort to implement the medical device protections authorized by the 1976 Medical Device Amendments to the Food, Drug, and Cosmetic Act.

Since the 1983 report was released, legislative and administrative attention has been focused on three areas: The requirements for mandatory reporting of hazardous medical devices, the regulation of cardiac pacemakers and leads, and the need to assess the safety and effectiveness of medical technology.

(A) MANDATORY REPORTING REQUIREMENTS

(1) Issues

Each year millions of Americans come into contact with some kind of medical device. Such devices range from the very simple, such as tongue depressors and thermometers, to the very complex, such as dialysis machines, artificial limbs, and pacemakers. The industry is diverse and growing—industry sales are estimated at between $12 and $14 billion a year. Ideally, some of these devices have the power to save lives. However, unsafe or ineffective devices can just as easily threaten lives. In order to minimize these risks, the Food and Drug Administration was given the authority to regulate the medical devices industry by the 1976 Medical Device Amendments to the Food, Drug, and Cosmetic Act.

The 1976 amendments gave FDA the authority to classify and control medical devices, ban dangerous medical devices, notify health professionals of dangerous medical devices, order manufacturers to redress harm caused by dangerous medical devices, require records and reports to be maintained, and require manufacturers to follow good manufacturing practices. Despite the comprehensive grant of authority to FDA, enforcement depends primarily on the quality and quantity of information the FDA receives about the medical devices industry—information about complaints, injuries, and deaths. Until recently, however, there was no requirement that manufacturers notify FDA when they learned that their devices had caused an injury or death.

(2) Administrative Action

While the 1976 amendments authorized FDA to impose such a requirement, and FDA issued a proposed rule regarding mandatory reporting in 1980, no definitive action was taken until the House Energy and Commerce Subcommittee on Health and the Environment held a hearing in February 1984 to discuss FDA's implementation of the 1976 amendments. At that hearing, FDA acknowleged the need for a mandatory reporting system, and in September 1984, FDA issued a final rule which "requires manufacturers and importers of medical devices, including diagnostic devices, to report to FDA whenever the manufacturer or importer receives or otherwise becomes aware of information that reasonably suggests that one of its marketed devices (1) may have caused or contributed to a death or serious injury or (2) has malfunctioned and that the device or any other device marketed by the manufacturer or importer would be likely to cause or contribute to a death or serious injury if the malfunction were to recur." This rule, effective November 13, 1984, is intended to assure that FDA is informed promptly of all serious problems or potentially serious problems associated with marketed devices and should help to prevent poor information flow and the resulting failure to regulate.

(B) CARDIAC PACEMAKERS AND LEADS

(1) Issues

One specific medical device found to need more effective regulation was the cardiac pacemaker. On September 10, 1982, the U.S. Senate Special Committee on Aging convened a hearing to review the findings of a year-long investigation of the purchase and use of cardiac pacemakers under the Medicare Program. At that time, it was estimated that costs associated with pacemaker implantation cost Medicare more than $2 billion. The committee concluded that the necessity or appropriateness of as much as half that total cost could be questioned as resulting from such things as unreasonable increases in cost made by hospitals above the cost charged by manufacturers, overutilization, narrowly drafted warranties limiting the manufacturer's liability to only those expenses not paid by Medicare or other third-party payers regardless of fault, performance or recall, overly generous payment rates and frequency schedules for followup and monitoring of pacemaker performance, and a number of creative marketing devices such as kickbacks, consulting fees, rebates, and other improper inducements to use pacemakers. Based on these findings, the committee recommended a number of changes including the establishment of a pacemaker registry to track device performance, protect beneficiaries, and ensure the proper collection and credit of manufacturers' warranties, the review and reduction of physician payment screens, and the development of procedures for the proper evaluation of devices explanted from Medicare beneficiaries.

Similar problems and the need for reform were revealed at a March 1984 hearing by the House Energy and Commerce Subcommittee on Oversight and Investigations, which was held to inquire into the marketing and use of defective pacemaker leads which conduct electrical stimulation from the pulse generator to the heart. The hearing revealed a 3-year history of malfunctioning of pacemaker leads or wires, of which the FDA was aware, but about which it took no meaningful action.

(2) Legislative Action

In order to address the many problems associated with pacemakers that were highlighted in the Senate Aging Committee's hearing in September 1982 and the pacemaker lead problems disclosed in the House hearing of March 1984, Senator Heinz and Representative Wyden introduced identical bills, S. 1622, the Pacemaker Patient Protection Act, and H.R. 3590, the Medicare Pacemaker Payment Reform and Patient Protection Act. Provisions of these bills were in large part incorporated into the Deficit Reduction Act of 1984.

The enacted provisions require the Secretary of Health and Human Services to revise the current guidelines on the frequency of transtelephonic monitoring. The law also requires the Secretary to review and report to Congress on the appropriateness of payments for implantation or replacement of pacemakers under parts A and B of Medicare. The Secretary, through the FDA, will create a registry of all cardiac pacemakers and leads for which payment was made under Medicare. Provider and physician compliance with the registry's information requirements is a condition for receipt of Medicare payments for implantation or removal of pacemakers or leads. This registry will make it possible to trace the performance of pacemakers and leads. Finally, the law authorizes the Secretary to require that any device or lead removed from a Medicare patient be returned to the manufacturer and to require the manufacturer to test or analyze each returned cardiac pacemaker or lead and to provide test results to the provider along with information as to any warranty coverage offered by the manufacturer.

(C) MEDICAL TECHNOLOGY ASSESSMENT

(1) Issues

It is believed that the new prospective payment system makes the need for cost-efficient technology assessment important since it may act as a disincentive to change accepted patterns of treatment and to permit otherwise obsolete technologies to remain in use. Supporters of technology assessment argued that an active program of assessment was needed to evaluate new and emerging technologies and reviews of those already in widespread use. Supporters also stated that it would help to provide useful information to practitioners so that they can determine what procedure or technology they should employ in a particular case and will help to assure the individuals subjected to certain medical procedures that they have received a careful review for safety and effectiveness.

(2) Legislative Activity

Medical technology assessment received much attention during the 98th session of Congress—it was the subject of a number of separate bills which were finally distilled into one amendment attached to the vehicle of S. 771, the Health Promotion and Disease Prevention Amendments of 1984. The bill, which was passed on October 30, 1984, transforms the National Center for Health Services Research into the National Center for Health Services Research and Health Care Technology Assessment. This bill gives to the center the expanded function of studying the safety and effectiveness and consequences of health care technology and the responsibility of advising the Secretary of Health and Human Services regarding reimbursement under federally financed health programs. The act also establishes the National Advisory Council on Health Care Technology which will serve as a clearinghouse for information on health care technologies and health care technology assessment.

3. QUACKERY

(A) ISSUES

Quackery—the promotion and sale of useless remedies promising relief from chronic and critical health conditions—is a practice targeted disproportionately at the elderly. A report submitted to Congress on May 31, 1984, by the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging concluded that, while senior citizens make up 11 percent of the population, they comprise 60 percent of the victims of health care frauds.

The House subcommittee report was the culmination of a 6-year series of investigations and hearings into the panoply of frauds against the elderly. The committee found that medical quackery is a massive problem and is growing at an alarming rate. In 1965, at hearings before the U.S. Senate Special Committee on Aging, it was estimated that quackery cost Americans $1 billion a year. Today, the House select committee estimates conservatively that it costs the Nation more than $10 billion.

A number of agencies—the Food and Drug Administration, the Federal Trade Commission, the U.S. Postal Service and the Department of Justice—share responsibility at the Federal level for preventing and controlling quackery. The House select committee found, however, that while each agency saw quackery as a booming problem, existing Federal efforts to control quackery are only minimal and resources available to combat quackery are diminishing.

The select committee made a number of recommendations aimed at combating medical quackery: It urged the Federal Government to increase its enforcement efforts by strengthening criminal penalties; to increase the powers of the Federal agencies involved; and to increase the necessary staffs and budgets. The committee stressed the need for greater public awareness and for a clearinghouse of information within HHS so that people can call to learn whether a proposed remedy is legitimate. The committee also proposed that Congress establish a mechanism for the impartial testing of unproven remedies and an interdepartmental task force to develop a plan of attack against quackery.

(B) LEGISLATIVE ACTIVITY

In order to implement those recommendations, Congressman Pepper introduced a package of related bills into the 98th Congress. H.R. 6049 would direct the Secretary of HHS to create a clearinghouse for consumer health education and information to provide consumers with data on efficacy, comparative costs, and possible side effects of drugs, medical devices, and treatment procedures. H.R. 6050 would increase the criminal penalties for those who willfully sell or offer for sale drugs, devices, or medical treatment knowing that it is unsafe, ineffective, or unproven for safety or efficacy. H.R. 6051 would establish within the Department of Justice a Strike Force on Health Quackery, composed of representatives from the FDA, the FTC, the Department of Justice, and the U.S. Postal Service, to study the sale and promotion of drugs, medical devices, and medical treatment procedures whose safety and effectiveness is either known to be futile or is not proven, and to coordinate Federal efforts to curb the sale and promotion of fraudulent health remedies. These bills were not passed, but may be reintroduced during the next session of Congress.

4. PATIENT PROTECTION

(A) ISSUES

As part of its ongoing efforts to safeguard the quality of care provided to Medicare and Medicaid recipients, the U.S. Special Committee on Aging held a hearing in May 1984 to highlight a serious defect in the ability of the Federal Government to protect the elderly and others from treatment by incompetent and dangerous medical practitioners. The problem stems from the limited authority possessed by the Secretary of the Department of Health and Human Services [HHS] to exclude practitioners from participation in, and reimbursement from, the Medicare and Medicaid Programs.

Licensing of health care professionals is a responsibility of the States, and practitioners can, and often do, hold licenses in more than one State. State licensing boards are empowered to sanction practitioners for their improper actions related to any patient, and when the board suspends or revokes a practitioner's license, he or she can no longer legally provide services in that State.

In sharp contrast to this broad State power, HHS has very limited authority to sanction practitioners. The Secretary is responsible only for practitioner's participation in Medicare and Medicaid, not for their other services, and can sanction practitioners, or exclude them from Medicare and Medicaid only for specific acts committed against those two programs and their beneficiaries.

Because of HHS' limited exclusion authority, practitioners who are found by the Secretary to be unfit to participate in Medicare or Medicaid in a particular State, or are found by a State licensing board to be unfit to practice in that State, pose a threat to all Medicare and Medicaid patients due to their ability to relocate to another State in which they are licensed and set up another practice with no assurance that the problems which led to their sanctioning in the first State were corrected before they began treating Medicare and Medicaid patients in the other State. This situation was confirmed by a General Accounting Office [GAO] investigation which revealed that Medicare and Medicaid patients are being treated in some States by doctors and pharmacists who have been stripped of their licenses to practice in other States for reasons which do not justify national exclusion from Medicare and Medicaid under the Secretary's current exclusion authority. The GAO also identified a number of specific problem areas and gaps in the Secretary's exclusion authority.

(B) LEGISLATIVE ACTIVITY

In order to close some of these loopholes, HHS announced plans to submit legislation which would expand the Secretary's exclusion authority to cover convictions for drug-related offenses and other crimes, and to exclude nationally from Medicare and Medicaid practitioners excluded from either program for reasons other than a criminal conviction against one of the programs. HHS is also establishing an information reporting system which will include public information on practitioners who have been excluded from Federal health care programs and from other public and private health care payment programs that choose to participate in the information system.

In response to the problems addressed at the hearing, Chairman Heinz and Senator Glenn of the Aging Committee introduced S. 2744, the Medicare and Medicaid Patient Protection Act of 1984, which would have significantly expanded the Federal Government's authority to exclude health care providers from Medicare and Medicaid. This bill would also have established a minimum exclusionary period of 5 years, instituted better coordination between Federal agencies and State sanctioning boards, imposed reporting requirements on State licensing authorities, and strengthened civil and criminal penalties. While the bill was not passed during the 98th Congressional session, it is likely to be reintroduced during the 99th session.

5. Drug Costs

(A) ISSUES

While persons aged 65 and over comprise 11 percent of the population, they pay a quarter of the national prescription drug bill. Thus, any lowering of drug cost would greatly inure to the benefit of older Americans. Generic drugs can cost up to 50 percent less than their name-brand equivalents, and it has been found that the substitution of generic drugs for brand name pharmaceuticals results in significant consumer benefits with no compromise in the quality of drugs that consumers receive.

(B) LEGISLATIVE ACTIVITY

Older Americans will stand to benefit from passage of S. 1538, the Drug Price Competition and Patent Term Restoration Act of 1984, which offers them significant savings in meeting escalating medical costs. The act aims at stimulating price competition through streamlining the approval process for generic drugs.

The act is a merger of two different concepts. First, it creates, a legal framework through which abbreviated new drug applications for generic drug products can be approved. With the implementation of a legal framework and procedure, it it hoped that generic drug applications will be approved more quickly than in the past, that generic drugs will be put on the market faster, and that these changes will stimulate price competition which will benefit consumers. The second feature of the act is the creation of a patent extension or period of exclusivity for chemical formulas which allows the pioneer manufacturer of a drug to recoup time lost while the Food and Drug Administration conducts its approval process.

The act strikes a delicate balance between the pharmaceutical industry and generic drug manufacturers: It allows pioneer manufacturers to reap the benefit of the full patent term promised by law and it speeds and simplifies the process for approving generic drugs and getting them on the market. While the law is complex and may lead to litigation and legislative amendments, there is already evidence of the success of the act's intent. Within 1 month after this new law went into effect, approximately 400 abbreviated new drug applications for generic drug products were submitted to the FDA. Prior to the passage of S. 1538, the FDA might have received that many applications in a year.

6. DECEPTION

Consumer interests also received attention in a hearing before the Subcommittee on Oversight and Investigations of the House Committee on Energy and Commerce. The oversight hearing was held in the wake of plans announced by the Chairman of the Federal Trade Commission [FTC] which would narrow the FTC Commissioner's authority to prohibit deceptive practices.

(A) ISSUES

For over four decades, the definition of deceptive acts and practices under section V of the Federal Trade Commission Act has been judicially construed to reach those practices which had the tendency or capacity to mislead and thereby reached a substantial number of consumers. In 1982, however, the FTC Chairman proposed that Congress change this definition legislatively in order to narrow the category of acts and practices which the Commission could prohibit as deceptive.

The chairman would have defined "deceptive" to include only those acts or practices likely to mislead consumers, acting reasonably in the circumstances, to their detriment. This definition significantly alters the traditional standard in three ways:

First, it requires that the act or practice be one that is likely to mislead consumers before it will be prohibited. Thus, practices which have the tendency or capacity to mislead, and would therefore have been illegal under the traditional standard, would no longer be prohibited.

Second, the chairman's standard provides a defense to those who can successfully argue that consumers misled by their practices were acting unreasonably. This would change a half century of law which protected the unwary, underprivileged, and the inexperienced, as well as the sophisticated or suspicious consumer.

Third, the chairman's statement appears to require a showing of harm to the consumer resulting from the act or practice in question before the Commission can prohibit the practice as a violation of the law. Under this standard, agencies would no longer be able to deter fraud in its incipiency as they have done in the past. The deceptive practice or fraud itself would no longer be a sufficient basis to trigger the jurisdiction of the Commission.

(B) LEGISLATIVE ACTIVITY

After a review of the traditional definition of deception with the chairman's more narrowly defined one, the House subcommittee concluded that consumers are better protected by continued adherence to the traditional standard which was set by the U.S. Supreme Court more than 50 years ago. Fearing that the changes in the law would turn consumer law back toward the harsh standard of caveat emptor—let the buyer beware—the subcommittee expressed its strong opinion that the traditional policy continue in the future.

7. Banking and the Elderly

Deregulation of financial services has brought intense competition and higher costs to bankers. Bankers, in turn, are imposing service fees, branch closures, and other unsettling changes on consumers—changes which may be victimizing lower-income, elderly and other less-profitable segments of the consumer population.

(A) ISSUES

Until recently, banks were forbidden by law to compete for consumer deposits by paying market interest rates. Thus, they competed in terms of providing convenience and service, investing heavily in constructing and staffing local branches, and attracting as many depositors as possible. The high operating costs involved with this kind of service approach were offset by the low interest expenses mandated by law. However, since the time that interest rate ceilings were lifted, banks are no longer willing or able to offer costly services and convenience without charging higher prices. They now face increased competition from savings and loans and nondepository institutions which have a less costly delivery system and a more varied product line and therefore market their services predominantly on the basis of interest rates paid by targeting the most profitable consumer segment—that is, those with high balances.

Banks have also begun to alter their entire mode of delivering financial services: they have raised service charges on checking accounts, eliminated unprofitable offices and increased the use of automated teller machines. Some institutions will open checking accounts only for those who earn enough to qualify for a major credit card. Others refuse to cash noncustomers' Government assistance checks, such as Social Security checks, or charge fees as high as $10 to do so. Some institutions have increased the minimum balance required to open a checking account and have imposed fees for such things as making "excessive withdrawals" from savings accounts, keeping small saving account balances, and using live bank tellers instead of automated teller machines.

These changes impact heavily on the elderly and poor. They reduce the availability of personal assistance and impose a heavy financial burden on those living on fixed and low incomes. There is a real danger that these people will be unable to afford what has become a necessity of modern economic life—a checking account.

(B) LEGISLATIVE ACTIVITY

A number of States have considered this problem in the last year. New York, for example, considered legislation that would let State-chartered banks get into the insurance business, but only if they offer lifeline banking—a package of basic banking services offered to the poor at a minimal cost. Activity at the State level, however, has been minimal and sporadic and no comparable legislation has yet been considered at the Federal level.

Activity at the Federal level has instead focused on another problem related to deregulation—the explosion in the development and advertising of creative interest-earning types of investments. Because there are many different ways to calculate interest rates, it is possible that two banks advertising the same rates would actually arrive at different payment amounts. Thus, bank advertisements may be very confusing and misleading to the consumer. In order to facilitate accurate comparisons and informed choices, Representative Lehman introduced H.R. 5232, the "Truth in Savings Act," on March 22, 1984. The purpose of the act is to require the clear and uniform disclosure of the rates of interest which are payable on savings instruments so that consumers can make a meaningful comparison between the competing claims of depository institutions. While the legislation was not passed, it is expected to be reintroduced. Should it pass, it could help enhance economic stability and competition and strengthen the ability of consumer to make informed decisions with regard to their savings.

8. Telecommunications and the Elderly

(A) ISSUES

Older Americans are more dependent on the telephone than perhaps any other segment of our society. For those with limited mobility or illness, and the homebound, the telephone may provide their only contact with the outside world and may be their only means to summon help in an emergency or to secure necessary provisions, such as food and medicine. A 1981 study by the American Association of Retired Persons found that older Americans use the telephone more than when they were younger and that it is a more important means of staying in touch with relatives and friends than ever before. This is especially true for persons over 75 years of age. While telephone service is extremely valuable and important to all persons, it is literally the lifeline of the elderly.

Two early major legislative efforts contributed to the widespread availability of telephone service that this country enjoys. These are the Communications Act of 1934 and the Rural Electrification Act. The Communications Act stated the goal of universal service at reasonable rates—making available, so far as possible, to all people of the United States a rapid, efficient nationwide and worldwide wire and radio communication service with adequate facilities at reasonable charges. The Rural Electrification Act provides for low interest loans to furnish and improve rural telephone service. Efforts to establish universal telephone service in this country have been highly successful—nearly 95 percent of American households have telephone service. The availability of telephone service to all Americans however, has been threatened by changes in the telecommunications industry.

The recent melding of communications and information due to technological advances and the entrance of marketplace competition into a previously monopolistic telephone industry have prompted both a restructuring of the telecommunications industry and an examination of the major laws and policies which regulate its activities. Among the most significant actions taking place in the telephone industry are the recent divestiture of the American Telephone and Telegraph Co. and its entrance into unregulated markets and modification of major Federal regulatory policies which govern industry behavior. These changes in the industry have caused substantial local rate increases which threaten the ability of people, especially rural and low income consumers, to maintain telephone service.

The elderly are particularly vulnerable to increases in telephone rates since so many live on low or fixed incomes and cannot afford high monthly access charges or increased telephone rates. Indeed, a survey of 1,504 persons conducted for the American Association of Retired Persons in December 1984 found that more than 1 in 5 older Americans say they have had to curtail their use of telephone due to higher costs. Among those who have incomes of less than $8,000 per year, 35 percent report having to cut down on their phone use. According to the survey, three-quarters of all older persons have seen their local phone service rates increase while only 10 percent reported that their long-distance bills have gone down. Additionally, two-thirds of those surveyed claim that it is now more confusing to make decisions about telephone service than it was a year ago, even though they use the phone more now and it is more important to them than ever before.

(B) LEGISLATIVE ACTIVITY

The great concern over the impact of substantial local rate hikes on telephone subscribership voiced by many consumer groups and public utility commissioners, prompted Congress to turn to an examination of the cumulative impact which the recent divestiture and Federal Communications Commission (FCC) policies will have on the outlook for affordable universal service. Congress held hearings in an attempt to gain further insight into this issue and introduced numerous measures to, among other things, ensure the availability of basic telephone service at reasonable rates and to modify, void or delay implementation of the FCC's policy changes.

In response to petitions for further reconsideration of FCC actions and mounting congressional concern, the FCC delayed implementation of changes and adopted modifications which had the effect of quelling support for major legislative changes and made immediate congressional action during the 98th Congress less critical. As a result, no major telephone legislation was passed in 1984. The delays have given legislators some extra time to consider additional information so that they will be better able to assess the impact on universal service, competition, and other important issues. Over the next several years, however, issues involving the restructuring of the telephone industry and significant policy changes will loom large and Congress will have to address, and remedy where necessary, the tremendous effect on suppliers, consumers and regulators.

Chapter 14

CIVIL LIBERTIES

OVERVIEW

Since ratification of the fifth and fourteenth amendments to the Constitution, which protects persons from being deprived of life, liberty or property "without due process of law" and prohibits the denial to any person of the equal protection of the law, respectively, this country has continuously expressed its commitment to the civil rights and liberties of its citizens. During the 1950's, significant civil rights legislation was enacted—primarily as an indication of renewed Federal legislative concern that, for various reasons, discrimination against certain segments of our society was taking place. Civil rights issues have recently gained attention once again primarily as a result of charges of lack of enforcement of existing civil rights laws.

While the country's awareness of the need to eliminate discrimination based on age has been somewhat slower to develop, significant gains were made with enactment, during the 1970's, of the Age Discrimination Act and the Age Discrimination in Employment Act. Congress recognized that older people, like minorities and women, were subject to discrimination and were also entitled to have civil rights protections. Civil rights legislation helps older persons to overcome discrimination they often face as a result of unfounded and outmoded stereotypes about aging. These sterotypes and myths have often acted to deprive older people the freedom to participate fully in society and to deny them the opportunity to reach their full potential.

This chapter reviews three legislative measures not addressed elsewhere in this volume which were introduced during the 98th session of Congress and which touch upon the liberties and rights of elderly and other persons. Although each of the bills had a different destiny, they deserve mention due to their impact or potential impact on the lives of the Nation's elderly.

The first of these measures is the Civil Rights Act of 1984, introduced in Congress in response to a Supreme Court decision that many felt would turn the tide of the civil rights movement, including the movement toward expanded civil rights of the aged, in this country. While the bill was killed before adjournment, hopes remain high for its eventual passage. The second measure is the Voting Accessibility for the Elderly and Handicapped Act, which was successfully passed and signed into law, and which helps to more adequately safeguard to the elderly and the disabled the basic right to vote. Finally, amendments passed by Congress to permanently extend the Equal Access to Justice Act, which helps allow persons of modest means to defend against unjustified government action, was vetoed by the President, disappointing many who advocate on behalf of the elderly.

A. CIVIL RIGHTS ACT OF 1984

The civil rights movement in the United States during the 1950's and 1960's resulted in a number of laws which dealt with discrimination and bias against disadvantaged groups in American society. In title VI of the Civil Rights Act of 1964, for example, Congress prohibited discrimination on the basis of race, color, or national origin in programs or activities receiving Federal financial assistance. In title VII of the Civil Rights Act, Congress made it unlawful for many private employers to discriminate on the basis of race, color, sex, religion, or national origin.[1]

Against this background, Congress, in November 1975, enacted the Age Discrimination Act as part of the amendments to the Older Americans Act. The act prohibits discrimination on the basis of age in all programs and activities receiving Federal financial assistance and prohibits recipients from taking actions that result in denying, or limiting services, or otherwise discriminates on the basis of age. Congress also passed four new policies and programs between 1972 and 1976 designed to end what some believed to be pervasive sex discrimination in American education. One of these, title IX of the Education Amendments of 1972, was modeled after the Civil Rights Act of 1964, and prohibits discrimination on the basis of sex in most education programs and activities receiving Federal financial assistance.

Proponents of strong nondiscrimination laws have complained that coverage under title IX and other civil rights laws has been too limited and that enforcement of the laws has been inadequate. On the other hand, some people believe that the Federal Government has too broadly interpreted coverage provisions and has levied too heavy a hand in the way that it has enforced the civil rights laws, including title IX. They feel that financial and administrative burdens have been imposed that far outweigh any benefits gained. Title IX has recently become part of a larger controversy as to whether the protections afforded by the civil rights laws have been effective and whether enforcement of those laws has been adequate.

Activity in the area of civil rights during 1984 was largely in response to the Supreme Court's February 1984 decision in *Grove City College* v. *Bell*, USLW 4238 (February 28, 1984) which centered on title IX of the Education Amendments of 1972. Many Members of Congress felt that the *Grove City* ruling severely narrowed the application of coverage of title IX, and they anticipated that, as a result of changed agency enforcement practices and subsequent judicial interpretations, other antidiscrimination statutes would be similarly narrowed. Indeed, as a result of the *Grove City* ruling, the Reagan administration immediately closed at least 23 civil rights investigations and narrowed the scope of 18 others. Legislation was introduced in 1984 to reaffirm the pre-*Grove City* judicial and executive branch interpretations and enforcement practices which provided for broad coverage of these antidiscrimination statutes.

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[1] While Congress was acting on title VII of the Civil Rights Act, it considered including age as a proscribed basis for employment discrimination but concluded that further studies on age discrimination needed to be conducted. The Age Discrimination in Employment Act of 1967 (ADEA) was enacted in response to the Secretary of Labor's report to extend equal employment rights to the aged. While the ADEA is essentially modeled after title VII of the Civil Rights Act, it borrows the enforcement provisions of the Fair Labor Standards Act (FLSA). Thus, ADEA remains a separate and distinct piece of fair employment legislation which is discussed in chapter 4.

1. Issues

Title IX of the Education Amendments of 1972 prohibits discrimination on the basis of sex in most education programs and activities receiving Federal financial assistance. The legislative history of title IX and of other antidiscrimination statutes dealing with race, national origin, handicap, and age, evidence a strong congressional intent to require broad coverage of the antidiscrimination provisions. Prior to 1981, Federal agencies charged with administering the distribution of Federal assistance and enforcement of the antidiscrimination statutes promulgated regulations which also spoke in terms of broad coverage. For example, the U.S. Department of Health, Education, and Welfare, and later the U.S. Department of Education, interpreted title IX broadly to mean that if any part of an institution received Federal funds, all parts of the institution were subject to the antidiscrimination statute. In addition, U.S. antidiscrimination statutes have a rich history of judicial interpretations which embrace broad coverage.

The U.S. Department of Justice originally concurred in this broad interpretation, but, in August 1983, after raising the issue in several other cases, it filed a brief with the U.S. Supreme Court in *Grove City College* v. *Bell,* in which it argued that title IX coverage should be restricted to the specific program that receives assistance, rather than the institution as a whole. Until that time, the Government had consistently argued that title IX coverage for the entire undergraduate institution operated by Grove City College was authorized by the statute.

The specific issues raised in the *Grove City* case were, whether the receipt of Federal financial assistance by students [Pell grants and guaranteed student loans] was sufficient to subject the college to title IX and, if so, whether the entire institution would be subject to title IX or only a more narrowly defined part of the institution, such as its financial aid program.

On February 28, 1984, the Supreme Court ruled that the receipt of Federal financial assistance by students was sufficient to subject the college to title IX, but that it applies only to the financial aid program receiving the Federal aid and not to the entire institution. Thus, in deciding that title IX did not bar sex discrimination in the institution as a whole, but affected only those departments or programs that actually received Federal aid, the Supreme Court applied a very narrow reading of the law.

Supreme Court Justice Marshall and Brennan dissented from the majority Court's opinion, stating that when financial assistance is intended to serve as Federal aid for the entire institution the institution as a whole should be covered by the statute's prohibitions on sex discrimination and that any other interpretation clearly disregards the intent of Congress and severely weakens the antidiscrimination provisions of title IX.

Civil rights, religious, and women's groups attacked the majority opinion, saying that it would narrow the scope not only of title IX, but also of similar Federal laws prohibiting discrimination on the basis of race, age or physical handicap. While the *Grove City* ruling interpreted only the Federal law against sex discrimination, nearly identical language is used in the statutes forbidding discrimination on the basis of race, national origin, age, and handicap. Like title IX, the 1964 Civil Rights Act, the 1973 Rehabilitation Act, and the Age Discrimination Act of 1975 prohibit discrimination in "programs or activities receiving Federal financial assistance."

Of the four civil rights statutes thought to be affected by the *Grove City* decision, the Age Discrimination Act of 1975 is of particular importance to the elderly. As previously mentioned, the act prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. Specifically, the act prohibits recipients from taking actions that result in denying or limiting services, or otherwise discriminate on the basis of age. It should be noted, however, that the act contains certain exceptions that permit use of distinctions which may have a disproportionate effect on the basis of age. Notwithstanding these exceptions, the act applies to persons of all ages. Like other Federal financial assistance civil rights statutes, the act applies only to programs or activities in which there is an intermediary (recipient) standing between the Federal financial assistance and the ultimate beneficiary of that assistance. It does not, for example, apply to programs of direct Federal financial assistance, such as the Social Security Program.

2. Legislative Activity

Immediately after the Supreme Court's decision in *Grove City* was handed down, several bills were introduced in Congress to overturn it by making institutionwide coverage of title IX automatic. On April 12, 1984, the Civil Rights Act of 1984 (H.R. 5490 (Simon)/S. 2568 (Kennedy)), was introduced in both the House and the Senate with numerous cosponsors to restore title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, to their pre-*Grove City* vitality.

The bill would amend the coverage provisions of the four civil rights laws by making three major changes in the four current laws: (1) Deletion of "program or activity"; (2) addition of a definition of "recipient"; and (3) amendment of the enforcement section of each law so that there could be no question that the Federal funding cutoff weapon would be directed at the "recipient," but that it would be limited to the particular assistance which supports the noncompliance.

Joint hearings on H.R. 5490 were begun by the House Subcommittee on Civil and Constitutional Rights, Committee on the Judiciary and the House Committee on Education and Labor on May 9, 1984. Witnesses testified regarding the need for the enactment of H.R. 5490, its potential impact on administrative compliance and pending litigation in the Federal courts, and the importance of congressional action in view of the Supreme Court's decision in *Grove City.* At the hearings, the Reagan administration opposed the bill on the grounds that it would be an unwarranted interference with State prerogatives and that there would be a major increase in litigation, in the Federal regulatory burden, and in the costs of civil rights enforcement.

In general, proponents of the Civil Rights Act of 1984 believe that the legislation will reinstate the original intent of Congress concerning the Government's ability to fight discrimination through civil rights legislation. Prime sponsors of the bill have stressed that the measure was not intended to expand any civil rights laws, but only to make clear Congress' original intent—that receipt of Federal funds subjects an entire institution to coverage by the laws. Opponents, on the other hand, contend that the bill is more than a mere reversal of the *Grove City* decision and that the bill will greatly expand Federal authority in this area. They assert that assistance of any kind to any part of any public or private enterprise will trigger all of the civil rights regulations and enforcement procedures of the Federal agencies with respect to all other parts of the enterprise or institution, no matter how remote from the part receiving assistance.

After being reported by both the Committee on Education and Labor and the Committee on the Judiciary on May 23, 1984 [House Report No. 98-829], H.R. 5490 was passed by the House on June 26, 1984, by a vote of 375 to 32, with 2 amendments. One amendment provided that members of Congress and the Federal judiciary may be considered recipients of Federal financial assistance for purposes of extending coverage of the four civil rights laws and the second amendment clarified that nothing in the act changes the status of black colleges or universities. Meanwhile, on May 24, 1984, the Senate began hearings on S. 2568. After Senator Orrin Hatch, chairman of the Senate Labor and Human Resources Committee, announced on June 14, 1984, that he feared it was too broad and that he needed more time to study the measure, the bill became stalled in committee.

Near the end of the session of the 98th Congress, however, the Senate voted to allow consideration of the measure in connection with a spending bill and later, voted overhelmingly to impose debate-limiting cloture on it. Despite these votes, the amendment ran into procedural difficulties and a compromise offered by Senate Republicans, which would have overturned the *Grove City* ruling for educational institutions only, was blocked by civil rights forces as unacceptable. Hopes for passage of the civil rights bill in 1984 were finally scuttled after a 53-45 vote to strip the rights measure from the continuing resolution. After the bill was tabled, sponsors of the measure decided not to push it further, but vowed to fight for the bill in the next Congress.

B. VOTING ACCESSIBILITY

The right to vote is one of our most valuable constitutional rights. Older Americans place the highest value on this right, participating in elections in proportions larger than those of any other group. Yet due to the architectural barriers and other conditions that exist at many of the polling and registration places in this country, older citizens with functional impairments have in many instances not been able to exercise this most precious right.

1. Issues

According to a 1980 survey by the National Center for Health Statistics, 31.5 million Americans, or 1 in 7, are limited in daily activity. An estimated 8 million people are considered severely disabled. A disproportionate number of these individuals are elderly—almost half of the 65-plus population has mild to severe activity limitation. This means that over 13 million older persons may encounter difficulties when they try to exercise their right to vote. In addition, elderly persons who are desirous of going to the polls may be prevented from doing so by other age-related problems, such as inability to secure transportation, fear of crime, and harsh weather conditions.

Responsibility for providing accessible polls resides with the State and with the political jurisdiction within the State responsible for conducting elections. While all States permit physically handicapped individuals to vote by absentee ballot, this option is not always adequate. In addition to the problem of early voting deadlines, there are also other impediments to their use, such as requirements that the voter provide a doctor's certificate or that the absentee ballot be notarized. And due to the potential for undue influence and voter fraud, States have enacted various restrictions on who may assist a voter in marking ballots or operating voting machines.

Judicial pronouncements in the area of access to the polls by disabled persons have sought to balance the voter's rights against the State's interest in maintaining the integrity of the electoral process and other State interests. In general, courts have ruled that not every limitation or incidental burden on the exercise of voting rights is subject to prohibition. Thus where the right to vote is not totally denied to physically handicapped persons and reasonable alternatives are provided, handicapped persons may not insist that all polling places be accessible.

Supporters of the disabled desire greater access to the polls in an effort to involve disabled persons in the election process. Because access regulations vary from State to State, many believe that there is a great need for model Federal legislation and uniformity. Others, however, are concerned that requiring States to make all polling places accessible will impose undue burdens on the State and taxpayers to benefit a small segment of the total population.

The Constitution gives Congress explicit authority to legislate with regard to congressional elections and there is a line of cases which indicate that they have such authority with regard to Presidential elections too. Until 1984, however, there was no uniform requirement that polls, at which elections for the President and Vice President of the United States, U.S. Senator, or U.S. Congressman, be accessible for handicapped voters. Congressional concern about voter participation and the lack of access to the polls by handicapped and elderly Americans led to the recent introduction in both the House and the Senate of legislation to provide that registration and polling places be accessible to handicapped and elderly individuals.

2. LEGISLATIVE ACTIVITY

On February 3, 1983, Congressman Hamilton Fish introduced H.R. 1250, the Equal Access to Voting Rights Act, which was referred to the House Committee on House Administration. Three hearings on the bill were held by the task force on elections beginning on October 12, 1983. On July 27, 1983, companion legislation (S. 1676) was introduced in the Senate by Senator Durenberger, along with Senators Heinz, Glenn, Dole, Weicker, Andrews, Biden, and Cranston. The bill, entitled the "Voting Rights for the Handicapped and Elderly Act," was referred to the Senate Committee on Rules and hearings were held on March 21 and 28, 1984. The testimony and written comments presented at the hearings reflected an awareness that much can be done to eliminate the barriers encountered by persons who are elderly or handicapped in registering and voting in Federal elections. Concern was also expressed that stringent Federal legislation in this area could impose substantial costs on States and localities charged with its implementation.

Having worked out differences in the two versions of the bills, the House and Senate passed an agreed upon measure which was presented to the President on September 20, 1984. It was signed by the President on September 28, 1984 as the Voting Accessibility for the Elderly and Handicapped Act [Public Law 98-435].

The stated purpose of the bill is to promote the fundamental right to vote by improving access for handicapped and elderly individuals to registration facilities and polling places for Federal elections. The act gives the chief election officer of each State the responsibility for promulgating guidelines to assure accessibility of polling places. The chief officer is empowered to grant exemptions from the accessibility requirements in the case of an emergency or if it is determined that no accessible facility is available or no site can be made temporarily accessible. If an exemption is granted, and upon advance request of a handicapped or disabled voter, the election officer must assign the voter to an accessible polling place or provide an alternative means of casting a ballot. Each State must report to the Federal Elections Commission every 2 years on the number of accessible and inaccessible polling places within the State. This information will be compiled by the FEC and submitted to Congress for a period of 10 years.

The act requires that a reasonable number of accessible permanent registration facilities be provided unless the State has mail or door-to-door registration procedures. States must make available voting instructions in large print for conspicuous display at registration and polling places and information on registration and voting by telecommunications devices for the deaf. Public notice of the availability of registration and voting aids is also required. The act eliminates, in most cases, the need for handicapped voters to obtain notarization or medical certification to receive an absentee ballot. Finally, it allows the Attorney General or an aggrieved individual to seek compliance with the law by bringing an action for relief in a U.S. district court, but only after the chief election officer has been notified of the alleged noncompliance and 45 days have elapsed since notification.

3. Conclusion

Passage of the Voting Accessibility for the Elderly and Handicapped Act, represents another step in a continuous process to protect and give meaning to the constitutional right to vote. Over the last several decades, for example, Congress has enacted major voting rights legislation to prevent discrimination against blacks and other language-minority voters. As late as 1982, Congress and the President acted to extend the protections of the Voting Rights Act so that minority voters would be not deprived of the right to register, to vote and to have their votes counted.

The act also reflects the continuing trend, emphasized in the Federal Rehabilitation Act of 1973, which authorizes a variety of training and service programs to the disabled, to help handicapped persons function independently and become self-supporting. The goal of the two acts is alike—that the disabled may fully participate in society and fully exercise their rights without discrimination on the basis of their handicap.

The right to vote is a fundamental right. It is not reserved to the young, the physically fit, or the mobile alone. The Voting Accessibility for the Elderly and Handicapped Act promotes the fundamental right to vote by requiring that registration and polling places be more readily accessible to the handicapped and elderly. Like other voting rights legislation, it attempts to end abridgements of voting rights. Finally, it helps to strengthen and further the commitment to ensure that everyone can exercise this precious right of citizenship and encourages the widest possible participation in the democratic process.

C. EQUAL ACCESS TO JUSTICE ACT

The Equal Access to Justice Act [EAJA] provides that in judicial and administrative proceedings in which the United States is the losing party, Federal courts and Federal agencies shall, in certain circumstances, order the United States to pay the attorney's fees of the prevailing party. The EAJA was originally enacted in 1980 as title II of Public Law 96-481. It was widely viewed as making it possible for the ordinary, private citizen of modest means and the small business person to bring legal challenges to unjustified actions of the Federal Government. The act was amended in 1982 by section 292 of Public Law 97-248. A new amendment, passed by Congress in October 1984, was vetoed by the President in November of that year.

1. Issues

In the United States, a court or agency may not ordinarily order one party to a proceeding to pay the attorney's fees of another. Hence a prevailing party is not entitled to collect attorney's fees from the loser and must usually bear this cost himself. This general rule, based on the common law, has numerous statutory exceptions most of which Congress enacted in order to encourage private litigation to implement public policy in areas it thought desirable. The rule also has two major common law exceptions which derive from the historic authority of the courts to do equity in particular situations. In addition, the common law doctine of sovereign immunity has prohibited suits and awards of attorneys' fees and other costs against the United States. Here too, however, there are numerous exceptions and about 40 statutes appear to permit awards of attorneys' fees against the United States.

Proponents of fee shifting argue that to be made whole, a person unjustly injured should not have to bear the expense of a lawyer. Others argue, however, that one has a right to sue or defend himself without bearing the risk of having to pay the attorney's fees for both sides. Another line of argument involves questions of which method will more effectively further the public policy of encouraging meritorious claims and pursuing valid defenses. Without fee shifting, some plaintiffs with meritorious actions and some defendants with valid defenses fail to assert them because of the expense involved and because the amount at stake is not always worth an attorney's time.

During the 1970's, Congress began a series of hearings to examine the availability of awards of reasonable attorneys' fees and related expenses and the possible need to expand such awards to appropriate prevailing parties. These hearings focused on the limited liability of the United States for attorneys' fees. The hearings culminated in the enactment of the EAJA in 1980. The EAJA was enacted because Congress found that the expense involved may be deterring parties from seeking review of, and defending against, Government action that was not substantially justified.

The EAJA allows awards of attorneys' fees against the United States in two broad situations. The first, codified at 28 U.S.C. 2412(b), makes the United States liable to the same extent any other party would be liable under the common law and statutory exceptions, including those that do not specifically authorize fee awards against the United States. This provision contains no expiration date, nor are there any limitations on the assets or number of employees of parties eligible to recover fees, and no maximum hourly rate for fee awards. This provision was in the original EAJA and was not affected by either the 1982 or 1984 amendments.

The second broad situation in which the EAJA authorizes awards of attorneys' fees against the United States is codified at 5 U.S.C. 504 and 28 U.S.C. 2412(d). These sections provide that, in specified agency determinations and in all civil actions (other than tort actions and tax cases) brought by or against the United States, the United States shall be liable for the attorneys' fees of prevailing parties unless it proves that its position was "substantially justified" or that "special circumstances" make an award unjust.

A limitation under these provisions is that fee awards may be made for work performed in administrative proceedings only if those proceedings were an adversary adjudication (an adjudication in which the Government position is represented by counsel or otherwise). As the legislative history of the EAJA makes clear, this limitation was designed to exclude agency adjudications, in which the Government does not take a position, such as those of the SSA.

In order to be eligible for an award of attorneys' fees, a party must be: (1) An individual whose net worth does not exceed $1 million; (2) the sole owner of an unincorporated business or a partnership, corporation, association, or public or private organization (other than an agency) having a net worth not exceeding $5 million and no more than 500 employees; and (3) any charitable or other tax-exempt organization regardless of net worth or number of employees. The law sets a maximum for fee awards of $75 per hour unless the court or agency determines that a special factor justifies a higher fee. This portion of the EAJA was, by the terms of the original act, repealed effective October 1, 1984.

According to a House report on the EAJA, during fiscal years 1982 and 1983, only 72 awards were granted, totaling less than $2.5 million. Of 192 applications filed for awards in administrative proceedings, only 8 resulted in awards—with the total amount awarded less than $36,000. At the court level, of the 166 cases where fee applications were filed and closed in 1982 and 1983, 64 resulted in awards, totaling $2,421,010. These awards were dramatically less than the $100 million annual cost estimated by the Congressional Budget Office in 1981 and higher amounts predicted by the Justice Department.

2. 1984 Amendments to the EAJA

Because of the sunset provisions in the law, Congress passed a set of amendments permanently extending the EAJA just before it adjourned for the year. Besides extending the original provisions of the EAJA, the amendment would somewhat further expand the liability of the United States for attorneys' fees and other expenses. It does so by making it clear that Federal courts and agencies may order the United States to pay attorneys' fees unless its position was substantially justified, not just with respect to its conduct of the adjudication or litigation, but also with respect to the underlying action that led to the adjudication or litigation. It broadens the class of parties eligible for fee awards by raising the maximum assets a party may have and by including units of local government. It permits the United States and other parties to appeal fee determinations and gives the courts a broader scope of review in such cases. Finally, it authorizes fee awards against the United States in actions for judicial review of any agency action, not just of adversary adjudications.

The bill as passed was submitted to the President for his signature, but he vetoed the measure in November 1984. The reason given for the veto was the White House's opposition to a provision which expands the definition of position of the United States to include the underlying agency action. As a result of the veto, EAJA provisions creating a right to fees against the United States based on the "substantially justified" standards are repealed as of October 1, 1984. Cases pending at the time of the repeal, however, will continue to be covered under the EAJA through their final disposition.

3. CONCLUSION

The EAJA expanded the liability of the United States for attorneys' fees and other expenses in certain administrative proceedings and civil actions. The primary purpose of the act was to ensure that certain individuals and other organizations would not be deterred from opposing unjustified governmental action because of the expense involved in securing the vindication of their rights. The act helped to reduce the disparity in resources between individuals, small businesses, and other organizations with limited means and the Federal Government.

Under the original EAJA, the number of eligible parties that have applied to recover fees has been low. In 1983, parties prevailed against the United States in an estimated 18,000 suits. During that year, however, only 108 parties applied for awards under the EAJA and 64 awards were made. The relatively low number of applications filed may be because attorneys do not have knowledge of the program. While the number of applicants is low, it is not unreasonable to believe that the expiration of the program will at times be a disincentive to the bringing of a meritorious claim against the Government and that some individuals and small businesses will forgo undertaking a justifiable defense because of the great expense in pursuing litigation in this country.

SUPPLEMENTAL MATERIAL

Supplement 1

1984 HEARINGS HELD BEFORE THE SENATE SPECIAL COMMITTEE ON AGING

SOCIAL SECURITY DISABILITY REVIEWS: THE HUMAN COSTS, PART 1, CHICAGO, IL, FEBRUARY 16, 1984, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

WITNESSES

Vera M. Heiser, Darion, IL.
Donald Vance, Chicago, IL.
Alberta L. Davy, Wheaton, IL.
Mark C. Hudson, Indianapolis, IN, regional director, National Association of Disability Examiners.
Zena Naiditch, executive director, Developmental Disabilities Protection and Advocacy Board, Chicago, IL.
Barbara Samuels, Northwestern University Legal Clinic; accompanied by Joseph Antolin, Legal Assistance Foundation of Chicago, IL.
Timothy H. Snyder, director of programs, Access Living of Metropolitan Chicago, IL.
Jess McDonald, assistant to the Governor for human services, Springfield, IL.
Robert W. Granzeier, director, Department of Rehabilitation Services, State of Illinois, Springfield, IL.
Philip Bradley, administrator, Bureau of Disability Adjudicative Services, State of Illinois, Springfield, IL.

SOCIAL SECURITY DISABILITY REVIEWS: THE HUMAN COSTS, PART 2, DALLAS, TX, FEBRUARY 17, 1984, HON. J. J. PICKLE PRESIDING

WITNESSES

David Ross, Dallas, TX.
Pauline Garretson, Dallas, TX.
John Roberts, Dallas, TX.
Sybil Yarborough, Dallas, TX.
Robert McPherson, director of planning, office of the Governor, State of Texas, Austin, TX.
Vernon M. Arrell, commissioner, Rehabilitation Commission, State of Texas, Austin, TX.
Dale H. Place, deputy commissioner, Disability Determination Department, State of Texas, Austin, TX.

Reyes Gonzales, president, National Association of Disability Examiners, Elgin, TX.
Caroline Blackburn, director, Department of Human Services, Dallas County, TX.
Warren Gould, Esq., Fort Worth, TX.

SOCIAL SECURITY DISABILITY REVIEWS: THE HUMAN COSTS, PART 3, HOT SPRINGS, AR, HON. J. J. PICKLE (CHAIRMAN, SUBCOMMITTEE ON SOCIAL SECURITY) PRESIDING

WITNESSES

Hon. Bill Clinton, Governor, State of Arkansas.
Julius Kearney, Disability Determination Service, State of Arkansas.
E. Russell Baxter, Department of Human Services, Division of Rehabilitation Services, State of Arkansas.
Hon. Bud Canada, Arkansas State Senate.
Marilyn Rauch, Central Arkansas Legal Services.
Minnie E. Dormois, Office of Hearings and Appeals, Fort Smith, AR.
Paul Michael Evans, Hot Springs, AR.
Hon. David T. Hubbard, Office of Hearings and Appeals, Fort Smith, AR.
Payton Kolb, M.D., Little Rock, AR.
Delbert Lewis, Little Rock, AR.
Hon. Francis Mayhue, Office of Hearings and Appeals, Fort Smith, AR.
Frederick S. Spencer, Mountain Home, AR.
Douglas Stevens, North Little Rock, AR.
Hon. Jerry Thomasson, Office of Hearings and Appeals, Fort Smith, AR.
Mildred Thompson, Lewisville, AR.
Denver L. Thornton, El Dorado, AR.

SOCIAL SECURITY DISABILITY REVIEWS, PARTS 1, 2, AND 3

Beginning in 1981, the Social Security Administration started reviewing the continuing eligibility of hundreds of thousands of disability beneficiaries. As the reviews progressed, many Members of Congress became concerned that they were being implemented improperly, and that SSA was unfairly denying benefits to people who deserved them. Between March 1981 and January 1984, more than 1 million reviews were conducted and almost 500,000 people were determined ineligible for benefits.

As part of an intensive congressional review of the review process, the Senate Aging Committee held three field hearings in 1984 to view the local effects of the disability crisis.

In Chicago, Chairman Heinz and Senator Percy held a hearing that drew a consensus that the reviews were deeply flawed, and that comprehensive reform legislation was urgently needed. Three people, whose eligibility had been reviewed and denied, graphically demonstrated the human effects of this problem. Four local advocates, as well as representatives of the Illinois State government, reinforced the need for reform.

In Dallas, the Aging Committee jointly held a hearing with the Subcommittee on Social Security of the House Ways and Means Committee. Senator Heinz, as well as Representatives J.J. Pickle and Martin Frost, heard testimony from citizens who had lost their eligibility, as well as from local and State officials.

Another joint hearing of the Senate Aging and House Ways and Means Committee was held in Hot Springs, AR. Senator David Pryor and Representatives J. J. Pickle and Beryl Anthony attended. The noteworthy aspect of this hearing was the testimony of a group of administrative law judges, who argued that SSA was inappropriately pressuring them to deny claims, and that special legislation was necessary to protect their independence.

The three field hearings documented universal agreement among beneficiaries, lawyers, advocates, doctors, disability examiners, and State officials on the need for remedial reform of the disability program. These hearings specifically provided support for H.R. 3755 and S. 476, pieces of legislation that were synthesized and enacted as the Social Security Disability Benefits Reform Act of 1984—Public Law 98-460.

MEETING THE PRESENT AND FUTURE NEEDS FOR LONG-TERM CARE, JERSEY CITY, NJ, FEBRUARY 27, 1984, HON. BILL BRADLEY PRESIDING

WITNESSES

Mary Rappaport, Medford, NJ.
Raymond Branagan, Bayonne, NJ.
Ann Charnowitz, Jersey City, NJ.
Mary Bongiovanni, Jersey City, NJ.
Marion Stiles, Medford, NJ.
Frank Gerne, Jersey City, NJ.
Vivian Thomas, Patterson, NJ.
Prof. Anne R. Somers, Department of Environmental and Community Medicine and Department of Family Medicine, University of Medicine and Dentistry of New Jersey, Rutgers Medical School, Princeton, NJ.
Dr. William J. Kane, medical director, Burlington Geriatrics Center, Memorial Hospital of Burlington County, Mount Holly, NJ.
Winifred Livengood, Princeton, NJ, executive director, Home Health Agency Assembly of New Jersey.
Lois Forrest, executive director, Medford Leas Life Care Community, Medford, NJ.
Carol Kientz, executive director, Christ Church Home Health Services, Jersey City, NJ.

ISSUES RAISED AND TESTIMONY SUMMARY

Senator Bill Bradley presided over this hearing to examine the needs of the chronically ill and how the Nation as a whole can address these needs. The marked improvement in medical technology has given the elderly a greater ability to live longer. These older Americans need a flexible health care program which can adjust easily to a long-term illness. There are not enough accepted alternatives offered between family care and nursing home care; too many people are ending up in nursing homes prematurely because they are unable to receive the proper care at home. Services which the chronically ill person will require over a long period of time are not necessarily provided for under any type of coverage. Many people often find themselves in the position of having too little money to pay for private care and yet too much money to qualify for Medicaid. Families become burdened with the responsibility of caring for their elderly relatives. This responsibility is accepted without question by many, but for others it is an impossible financial and mental hardship.

The Government must share the responsibility with the private sector, health care providers and private citizens in order to create a more flexible yet all encompassing manner in caring for the chronically ill. Senator Bradley suggested that the Government should consider expanding Medicare to cover the expenses of long-term care as well as investigate the possibility of insurance companies offering policies against a chronic illness. Senator Bradley's bill, the Senior Citizens Independent Community Care Act, which sets up State demonstrations to test the feasibility of providing home care services to elderly persons at risk of being institutionalized, was discussed at great length.

ENERGY AND THE AGED: STRATEGIES FOR IMPROVING THE FEDERAL WEATHERIZATION PROGRAM, WASHINGTON, DC, MARCH 2, 1984, HON. DAVID PRYOR PRESIDING

WITNESSES

Pat Collins, Under Secretary, U.S. Department of Energy, Washington, DC, accompanied by Donna Fitzpatrick, Deputy Assistant Secretary for Conservation and Renewable Energy; Richard Broncato, Deputy Director, State and Local Program Office; and Joe Flynn, Head, Weatherization Program.

Leslie Post, director, Minnesota Energy Assistance Program, St. Paul, MN.

Geoffrey Green, executive director, York County Community Action Organization, Sanford, ME, on behalf of National Community Action Foundation.

Wallace Minor, Philadelphia, PA.

Carol Werner, National Consumer Law Center, Washington, DC

Vita Ostrander, president, American Association of Retired Persons, Washington, DC

Robert Parr, on behalf of Pennsylvania Petroleum Association and National Oil Jobbers Council, Lebanon, PA.

Irene Stillings, manager of consumer affairs, Edison Electric Institute, and New York State Electric & Gas Corp., Binghamton, NY.

ISSUES RAISED AND TESTIMONY SUMMARY

At the beginning of fiscal year 1984, the Congress was considering legislation to extend and improve the Federal Weatherization Program. Energy costs faced by older Americans especially those at the poverty level, are alarming. Older people pay far more for energy as a percentage of their incomes than any other group—

nearly 30 percent of their average incomes compared to 8 percent for the average household. Those who are living on fixed incomes cannot make the substantial financial arrangements necessary to pay for escalating energy costs or for retrofitting to make their homes more energy efficient. As Congress addressed the need to reauthorize the DOE Weatherization Program, members of the committee felt that it must also be mindful of its continuing obligations to those who cannot readily adapt to price changes.

The committee heard testimony from the administration, consumer groups, State and local program officials, and representatives of several utility trade associations. Four specific issues were addressed by the witnesses. First, witnesses attested to the overall ravages of skyrocketing fuel costs, dramatizing the particular problems facing the elderly. Second, testimony was presented to support the need for a continued Federal commitment to those most affected by energy inflation. Third, an overwhelming number of witnesses supported the expansion of the program to include new energy-efficient technologies which would increase the overall cost effectiveness of the Weatherization Program. Fourth, testimony also focused on the administration's proposal to fund several energy conservation programs, including weatherization, from amounts resulting from petroleum pricing violations under the Emergency Petroleum Allocation Act of 1973.

MEDICARE: PHYSICIAN PAYMENT OPTIONS, WASHINGTON, DC, MARCH 16, 1984, HON. JOHN HEINZ PRESIDING

WITNESSES

Uwe E. Reinhardt, professor of economics and public affairs, Woodrow Wilson School, Princeton University, Princeton, NJ.

Vita Ostrander, president, American Association of Retired Persons, Washington, DC, accompanied by Jack Christi, Federal legislative staff, AARP.

William R. Hutton, executive director, National Council of Senior Citizens, Washington, DC.

Dr. James S. Todd, member, board of trustees, American Medical Association, Ridgewood, NJ, accompanied by Ross N. Rubin, director, department of Federal legislation, AMA.

Thomas H. Rice, Ph.D., assistant professor, Department of Health Policy and Administration, School of Public Health, University of North Carolina, Chapel Hill, NC.

Dr. Thomas L. Delbanco, associate professor of medicine, Harvard University, and director, division of general medicine and primary care, Beth Israel Hospital, Boston, MA.

Susan Babin, director, Bureau of Community Based Services, Rate Setting Commission, Commonwealth of Massachusetts, Boston, MA.

Jane B. Mitchell, Ph.D., vice president, Health Economics Research, Inc., Chestnut Hill, MA, accompanied by Jerry Cromwell, Ph.D., president.

ISSUES RAISED AND TESTIMONY SUMMARY

On March 16, 1984, the committee convened for a hearing to consider what may be one of the most critical issues for 1985 specifically, and for Medicare reform in general. As one in a series of hearings on the future of Medicare, the committee focused on methods of paying physicians.

Part B of Medicare, the supplemental insurance program, is the primary insurance program covering physician services expenses for Americans 65 and over. The part B program will cost $25 billion in 1985; it is the most rapidly growing major domestic program in the Federal budget. In 1985, part B will become the third largest Federal domestic program. Only Social Security and part A of Medicare will cost the Federal Government more.

The Aging Committee hearing looked specifically for alternative methods of paying physicians under Medicare, a system that would address some of the existing incentives in Medicare's fee-for-service method of reimbursement, those that reward physicians for providing excess services. Witnesses were asked to offer recommendations for payment methods that would give physicians an incentive to reduce costs while preserving quality care at a fair price.

The lead witness, Dr. Uwe Reinhardt presented an overview of the current reimbursement system and discussed the merits of various alternatives. Dr. Reinhardt described the ways in which reimbursement incentives affect physician behavior. The second panel, Vita Ostrander from the American Association of Retired Persons, and William Hutton from the National Council of Senior Citizens, presented testimony to the committee describing what patients want from their doctors, including quality, access, and affordability.

The second and third panels were comprised of research experts who discussed the advantages and disadvantages of various physician reimbursement systems and commented on legislative responses aimed at controlling physician costs.

At the hearing, the committee released a print, "Medicare: Paying the Physician—History, Issues, and Options."

REAUTHORIZATION OF THE OLDER AMERICANS ACT, 1984, WASHINGTON, DC, MARCH 20, 1984, HON. CHARLES E. GRASSLEY, CHAIRMAN, SUBCOMMITTEE ON AGING, AND HON. JOHN HEINZ, CHAIRMAN, SPECIAL COMMITTEE ON AGING, PRESIDING

WITNESSES

Hon. Dorcas R. Hardy, Assistant Secretary, Office of Human Development Services, Department of Health and Human Services, Washington, DC, accompanied by Dr. Lennie-Marie P. Tolliver, U.S. Commissioner on Aging, and David Rust, Director, Office of Policy and Legislation, Human Development Services.

Cyril Brickfield, chairman, Leadership Council of Aging Organizations, Washington, DC, accompanied by David Affeldt, consultant, American Association for Retired Persons.

Dr. Robert Binstock, professor, Brandeis University, Waltham, MA.

Jean Grant, commissioner, Citrus County, FL, on behalf of National Association of Counties, Washington, DC.

Hon. Robert M. Buhai, mayor, Highland Park, IL, on behalf of U.S. Conference of Mayors.
Hon. Candace S. Tongue, mayor, Wendell, NC, on behalf of the National Association of Regional Councils, Washington, DC, accompanied by George Gaberlavage, National Association of Regional Councils.

ISSUES RAISED AND TESTIMONY SUMMARY

The last in an extensive series of hearings on the reauthorization of the Older Americans Act, this joint hearing between the Special Committee on Aging and the Subcommittee on Aging of the Committee on Labor and Human Resources focused on the past, present, and future developments in the evolution of the act. The hearing provided an opportunity for committee members to summarize remaining issues under consideration with the 1984 amendments. The Older Americans Act was first enacted in 1965, and has evolved into one of the principal, federally sponsored, social service programs for older persons at the community level. The 1984 amendments marked the 10th time that the act had been amended in its 19-year history. Witnesses at the hearing included representatives from the administration, the leadership Council on Aging Organizations, and local governments, as well as a nationally recognized expert from the field of aging and public policy.

Several issues were examined in detail at the hearing, including the administration's proposal for a total consolidation of the separate authorizations under title III and the transfer of the title V program to the Administration on Aging. The hearing also focused on the appropriate role and responsibility of the Administrative on Aging, and its position within the Department of Health and Human Services. Local government representatives argued for an expanded role in the decisionmaking and service delivery strategies of area agencies on aging. Finally, long-term care and the future of the aging network in the provision of long-term care services received considerable attention. The hearing cleared the way for final Senate consideration and passage of the reauthorization bill.

LONG-TERM CARE: A LOOK AT HOME AND COMMUNITY-BASED SERVICES, GRANITE CITY, IL, APRIL 13, 1984, HON. CHARLES PERCY PRESIDING

WITNESSES

Frances Hargiss, Cottage Hills, IL.
Orville Prott, Edwardsville, IL.
Helen L. Cain, president, Illinois Council of Home Health Services, Alton, IL.
Jane Rimbey, director, Visiting Nurses Association of Morgan and Scott Counties, Jacksonville, IL.
Mary Lou Turcol, administrator, home health care department, Community Memorial Hospital, Staunton, IL.
D. Jeanne Tippett, senior vice president, Community Care Systems, Inc., East St. Louis, IL.
Roosevelt J. Peabody, executive director, Southwestern Illinois Area Agency on Aging, East St. Louis, IL.

Phyllis H. Pinkerton, executive director, East Central Illinois Area Agency on Aging, Inc., and president, Illinois Association of Area Agencies on Aging, Bloomington, IL.
C. Jean Rogers, Ph.D., manager, division of long-term care, Illinois Department on Aging, Springfield, IL.

ISSUES RAISED AND TESTIMONY SUMMARY

Senator Percy chaired this hearing to examine the problems of long-term community-based care and various home services currently available. Home health and supportive services is an effective way to avoid premature enrollment in nursing homes and the high costs of nursing home care. The elderly and the chronicaly ill who are fortunate enough to be able to stay at home but still require some care can benefit from these services. These supportive services are also very helpful to the families of the chronically ill.

Senator Percy heard testimony from private citizens discussing their individual needs and the help they receive through various programs. Helen Cain, representing the Illinois Council of Home Health Services, gave support to the continuation of the Medicare waiver of liability provision. A representative from the Visiting Nurses Association explained the problems created by new agencies entering the health care business, particularly the increase of costs generated by added competition. Senator Percy heard from witnesses describing the economic and administrative advantages in providing home health care in comparison to enrollment in an institution.

MEDICARE: PRESENT PROBLEMS—FUTURE OPTIONS, WICHITA, KS, APRIL 20, 1984, HON. NANCY KASSEBAUM PRESIDING

WITNESSES

Marilyn Moon, Ph.D., The Urban Institute, Washington, DC.
Hugh L. Smiley, chairman, Sedgwick County, Kansas, Council of Aging, Wichita, KS.
Marlon R. Dauner, senior vice president, external affairs, Blue Cross/Blue Shielf of Kansas, Topeka, KS.
Clyde Baker, president, District Lodge No. 70 Retirement Club, National Council of Senior Citizens, Wichita, KS.
Donald A. Wilson, president, Kansas Hospital Association, Topeka, KS.
Pat Moore, founder and coconvenor, Gray Panthers of Wichita, KS.
Dr. James Gleason, president, Kansas Medical Society, Topeka, KS.
Margaret Mullikin, Wichita State University Gerontology Center, Wichita, KS.
Irene Hart, director, Department of Aging, Sedgwick County, KS.

ISSUES RAISED AND TESTIMONY SUMMARY

Senator Kassebaum called a hearing to examine the impact of the declining financial status of the Medicare trust fund on recipients and on the health care system. Only a few weeks prior to the hearing, the Medicare board of trustees issued its annual report—indicating that the trust fund which supports Medicare part a (hospital) benefits will likely be depleted by 1991. Although not financed by the trust fund, Medicare part B (supplementary medical insurance) benefits are also a growing source of concern due to the rapid growth of this program.

Noting that the prospective payment system for hospitals offered a promising start, Senator Kassebaum also observed that additional steps would be needed. She pointed out that changes in a complex system must be planned will in advance if serious disruption is to be avoided. To assure a balanced and workable outcome, she emphasized the need for all interested parties to become educated about the extent of the problem and the options for addressing it.

This hearing brought together recipients and providers. The range of issues the witnesses raised highlighted the interrelationship between Medicare and the broader health care system. In addition to discussing specific features of Medicare, witnesses expressed interest in finding innovative uses for hospital facilities and in assuring the availability of appropriate noninstitutional services. Some of the beneficiaries on the panel noted that attempting to have an impact on the health care system is a bewildering and often frustrating task, particularly when one is old and in poor health.

Stressing the need to act before a crisis point was reached, Senator Kassebaum urged continued cooperative efforts toward a solution. She indicated that the hearing was one in a series of efforts by the Senate Special Committee on Aging and others to arrive at proposals which will be equitable to beneficiaries, providers, and taxpayers.

SHELTERING AMERICA'S AGED: OPTIONS FOR HOUSING AND SERVICES, BOSTON, MA, APRIL 23, 1984, HON. JOHN HEINZ PRESIDING

WITNESSES

Raymond L. Flynn, Mayor, Boston, MA.
Amy S. Anthony, secretary, Executive Office of Communities and Development, Commonwealth of Massachusetts, Boston, MA.
Richard H. Rowland, Ph.D., secretary, Department of Elder Affairs, Commonwealth of Massachusetts, Boston, MA.
Philip Abrams, Under Secretary, U.S. Department of Housing and Urban Affairs, Washington, DC.
Ellen Feingold, executive vice president, Jewish Community Housing for the Elderly, Brighton, MA.
Raymond J. Struyk, Ph.D., senior research associate, the Urban Institute, Washington, DC.
Pamela Shea-Roger, partner, OKM Associates, Inc., Boston, MA.
James P. Firman, Ed.D., senior program officer, Robert Wood Johnson Foundation, Princeton, NJ.
Robert D. Chellis, president, National Lifecare Corp., Chestnut Hill, MA.

ISSUES RAISED AND TESTIMONY SUMMARY

Federal housing policymakers must now make a serious examination of the broader shelter needs of America's aged and of policy options for addressing them. The commonly held goal to enable the elderly to remain in their homes as long as possible must be explored with diligence as the elderly population continues to grow. A corollary is that the frail elderly should be cared for in the least restrictive environment, both for the quality of life considerations and for cost effectiveness. Increasing numbers of older persons are in need of in-home assistance or supportive living environments. Accommodating these needs will require greater cooperation between Federal housing, health, and human services agencies to promote the expansion of shelter services.

In effect, the Federal Government needs to find ways to implement the principles of the congregate housing program for all persons in need, rather than just those few federally assisted housing projects. The demand for programs that coordinate housing, health care, and other supportive services will increase enormously in the next several decades.

Several of these forthcoming issues were addressed at a Senate Special Committee on Aging Hearing on April 23, 1984, entitled "Sheltering America's Aged: Options for Housing and Services," which examined the problems as well as the opportunities in providing appropriate shelter and services, especially the low-income frail elderly. Chairman Heinz received testimony from three panels of expert witnesses. The first panel examined public sector program and innovations such as the Massachusetts State Congregate Housing Program which has proven to be a cost effective, quality program in delivering appropriate care to the States' frail elderly population.

Under Secretary for Housing Abrams' testifying on the Federal efforts toward providing shelter, acknowledged the importance of the section 202 program and gave a positive preliminary report on the Federal Government's CHSP Program. The second panel of witnesses spoke to the needs of the frail elderly and the "aging in place" as a phenomenon for Federal concern. The third panel of experts reviewed a range of shelter options available presently on a fragmented basis such as shared housing and accessory apartments and the need to promote these underutilized options on a national basis. Witnesses also discussed the potential that home equity conversion has for providing independent living insurance to the 2.25 million elderly homeowners at risk of institutionalization. The estimated $70 billion in assets of these homeowners could generate an average of $3,000 per year per individual or home health care or long-term care insurance.

PROTECTING MEDICARE AND MEDICAID PATIENTS FROM SANCTIONED HEALTH PRACTITIONERS, WASHINGTON, DC, MAY 1, 1984, HON. JOHN HENIZ, CHAIRMAN, PRESIDING

WITNESSES

Dr. Robert C. Derbyshire, author and past president of the Federation of State Medical Boards, Santa Fe, NM.

Michael Zimmerman, Associate Director, Human Resources Division, General Accounting Office, accompanied by Tom Dowdal, Group Director, Human Resources Division, and Don Warsing, Evaluator, Human Resources Division, Washington, DC.

Richard P. Kusserow, Inspector General, U.S. Department of Health and Human Services, Washington, DC.

Dr. John J. Ring, member, board of trustees, American Medical Association, Mundelein, IL, accompanied by Ross N. Rubin, Department of Federal Legislation, American Medical Association.

William L. Wood, Jr., executive director, Office of Professional Discipline, State of New York, New York, NY.

R. Thomas Carter, legal counsel, Kentucky State Board of Medical Licensure, Louisville, KY.

ISSUES RAISED AND TESTIMONY SUMMARY

The purpose of this hearing was to investigate the Department of Health and Human Services' inability to prevent unfit health care practitioners from practicing medicine on Medicare and Medicaid patients. Senator Heinz stated that there is a tremendous gap in the laws protecting patients from unfit health practitioners. Doctors barred from practicing in one State, simply move to another State where they have a license and set up practice. It is a long and difficult process to find the offender and prosecute him after he has moved to another State. Many Medicaid and Medicare patients are especially vulnerable because of their poor health and financial situations: these victims cannot afford to fight back. Senator Heinz called on Members of Congress to give the Secretary of Health and Human Services the authority to crack down on these practitioners and stop this tragedy from continuing. The members of the committee also asked for more State interaction and cooperation to prevent practitioners from obtaining licenses in multiple states.

At the hearing the General Accounting Office released its report on the Government's inability to protect patients in federally supported health programs from unfit doctors. HHS Inspector General Richard P. Kusserow agreed with GAO's recommendations, and pledged to work with Senator Heinz on a legislative solution to the problems identified in the hearing.

A 10TH ANNIVERSARY REVIEW OF THE SSI PROGRAM, WASHINGTON, DC, MAY 17, 1984, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

WITNESSES

Martha A. McSteen, Acting Commissioner of Social Security, U.S. Department of Health and Human Services, Baltimore, MD.

Aleen C. Cook, Joelton, TN, accompanied by Jackie A. Beery-Day, paralegal, Legal Services of Middle Tennessee, Inc., Nashville, TN.

Terry W. Morris, coordinator, developmental disabilities program, Crawford County, PA, Mental Health/Mental Retardation Program, Meadville, PA, accompanied by Dale Roha, Meadville, PA.

Lee A. Hoffman, Jr., Esq., Hoffman, Silverberg & Wachtell, New York, NY.

John H. Noble, Jr., Ph.D., assistant commissioner, policy and resource development, Department of Mental Health and Mental Retardation, Commonwealth of Virginia, Midlothian, VA.

James H. Schulz. Ph.D., professor of economics and director of policy studies, Policy Center on Aging, Brandeis University, Waltham, MA.

Arthur S. Flemming, cochairman, Save Our Security, Washington, DC.

ISSUES RAISED AND TESTIMONY SUMMARY

In 1974, the Supplemental Security Income [SSI] Program began distributing monthly benefits to low-income aged, blind, and disabled recipients. SSI was established by Congress as an experiment in social policy, replacing three separate Federal-State programs with a coherent, unified, Federal program.

The Special Committee on Aging undertook a major review of the successes and failures of the first decade of the program in 1984. As part of this review, Chairman Heinz convened a hearing in Washington. The hearing focused on a number of issues, including administrative and technical problems in SSI, as well as a broad assessment of the degree to which SSI has accomplished its original goal.

Three SSI recipients testified, outlining the specific problems they had encountered. Their testimony generated support for S. 2569, SSI legislation introduced by Senators Moynihan and Heinz to fill many of the gaps in the program and improve its adminstration. The Commissioner of Social Security, Martha McSteen, testified on the administrative history and development of SSI, stressing improvements over time. Four expert witnesses reviewed the program from alternative perspectives. Lee A. Hoffman, Jr., a New York attorney discussed problems associated with the assets test, and the collection of overpayments. Dr. John H. Noble, Jr., a mental health official for the State of Virginia, examined issues related to work disincentives in the program, rehabilitation, and the mentally ill and mentally retarded.

Dr. James H. Schulz of Brandeis University provided an overarching assessment of SSI and stressed many of the shortfalls in the program. Dr. Arthur Flemming, former Secretary of the Department of Health, Education, and Welfare, recommended a number of changes in SSI, including increasing benefits to the poverty level.

Overall the hearing demonstrated basic agreement that SSI represents an advance from the earlier Federal-State programs, but that much needs to be done if the program is to achieve the fundamental goals of simplicity, fairness, and adequacy.

LONG-TERM CARE OF THE ELDERLY: A FEDERAL-STATE-PRIVATE PARTNERSHIP, SEATTLE, WA, JULY 10, 1984, HON. DANIEL J. EVANS PRESIDING

WITNESSES

Bruce Ferguson, assistant secretary, community services, department of social and health services, State of Washington, Olympia, WA.

Anne Kirchner Katterhagen, executive director, Hospice of Tacoma, Tacoma, WA.

Karen Wintringham, assistant to the senior vice president and chief financial officer, Group Health Cooperative of Puget Sound, Seattle, WA.

Daniel O. Wagster, senior vice president and regional manager, Kaiser Foundation Health Plan of Oregon, Portland, OR.

John F. Haugan, administrator, Lilac Plaza, Spokane, WA.

Hilde M. Birnbaum, Ph.D., vice chair, Senior Caucus of Group Health Cooperative of Puget Sound, Seattle, WA.

Laurie Jensen, chair, Washington State Legislative Committee, American Association of Retired Persons, Seattle, WA.

Dr. Richard F. Ambur, president, Washington State Medical Association, Seattle, WA.

Reva K. Twersky, member, Seattle-King County Advisory Council on Aging, Seattle, WA.

Marthanna E. Veblen, retirement counselor, Seattle, WA.

LaVerne Girke, Seattle, WA.

Thelma Wiseman, Seattle, WA.

ISSUES RAISED AND TESTIMONY SUMMARY

Chaired by Senator Daniel J. Evans, this hearing examined the existing relationships between Federal, State, and local programs which supply long-term care to the elderly and disabled. Senator Evans discussed the possible problems of caring for the frail elderly in the future and the need for development of both public and private long-term care delivery models. The need for a stronger intergovernmental partnership was recognized, with an emphasis on more community-based facilities which encourage the independence of the individual.

The first panel discussed the Omnibus Reconciliation Act of 1981 which grants States flexibility in developing their own system for long-term care. A representative from the State of Washington described the work Washington State has done to create a system which offers a range of services in caring for the elderly. Health care professionals explained health facilities which are now available to the elderly and what the alternatives are for comprehensive long-term care. The closing panel presented the viewpoint from the consumer recommending various economic and administrative changes in providing long-term care to the elderly.

LOW-COST HOUSING FOR THE ELDERLY: SURPLUS LANDS AND PRIVATE-SECTOR INITIATIVES, SACRAMENTO, CA, AUGUST 13, 1984, HON. PETE WILSON PRESIDING

WITNESSES

Alice J. Gonzales, director, California Department of Aging, Sacramento, CA.
Rev. Clark Harshfield, executive director, Retirement Housing Foundation, Los Angeles, CA.
Lee Grissom, chairman, Housing Commission, San Diego, CA.
Ben Montijo, executive director, Housing Commission, San Diego, CA.
Ivary Williams, volunteer, Senior Services Neighborhood House of San Diego, CA.
Dr. Gerald B. Kauver, director, Installation Planning, Office of the Assistant Secretary, U.S. Department of Defense, Washington, DC.
Earl E. Jones, acting commissioner, Federal Property Services Administration, U.S. General Services Administration, Washington, DC.
Edward R. Miller, chief land agent, Office of Real Estate Services, Department of General Services, State of California, Sacramento, CA.
Ward Connerly, Connerly & Associates, Sacramento, CA.

ISSUES RAISED AND TESTIMONY SUMMARY

Senator Wilson called this hearing to discuss the need for both Government and private industry involvement in creating quality low-cost housing for the elderly. There is a great need to develop comfortable, safe, and sanitary housing which the elderly can afford on a fixed income. The Government owns surplus land which currently is not bringing in any income but has potential for development. Senator Wilson called for ideas on how some of this land could be made available to the public in such a manner that it would be financially advantageous to all participating parties. The hearing focused particularly on examining innovative ways in which different levels of government—Federal, State, and local can cooperate with private industries willing to contribute to the construction of low-cost quality housing. Senator Wilson discussed the possibility of additional legislation to free Government-surplus lands for development and to create incentives for both private sector and Government involvement.

Alice J. Gonzales, director of California's Department of Aging, reviewed the current housing crises facing seniors in that State. Rev. Clark Harshfield, executive director of the Retirement Housing Foundation, outlined his proposal to raise additional sources of investment capital by utilizing existing equities in nonprofit housing corporations. The successful use of surplus Government lands developed by private enterprise was explained by Lee Grissom and Ben Montijo, both of the San Diego Housing Commission. Ivary Williams of Senior Services Neighborhood House described the need for elderly housing; he related his personal experience in San Diego in which local surplus Government land was utilized in an innovative program for senior housing. Senator Wilson was briefed by Gerald Kauvar, Director, Installation Planning of the Department of Defense with respect to the proposed changes to expidite the transfer of surplus military property for purposes of local housing initiatives.

THE CRISIS IN MEDICARE: EXPLORING THE CHOICES, ROCK ISLAND, IL, AUGUST 20, 1984, HON. CHARLES PERCY PRESIDING

WITNESSES

Dr. Carolyne K. Davis, Administrator, Health Care Financing Administration, U.S. Department of Health and Human Services, Washington, DC.

L. Boyd McIntire, president, Moline chapter, American Association of Retired Persons, and secretary, Illinois Council on Aging, Rock Island, IL.

Al Halx, chairman, Senior Education, Inc., Western Illinois Advocacy Project, Rock Island, IL.

Dr. George H. Burke, radiologist, Franciscan Hospital, Rock Island, IL.

Tim Kearns, director of fiscal services, Lutheran Hospital, Moline, IL.

Ruth J. Lee, executive director, Iowa-Illinois Health Care Alliance, Rock Island, IL.

ISSUES RAISED AND TESTIMONY SUMMARY

Senator Percy called this hearing to discuss the increasing demand for support from the health insurance trust fund—the Medicare Program—and what decisions we must make to insure that this fund remains solvent. The rising cost of health care has increased the dependency on Medicare and yet, if changes are not made, this demand could easily exhaust Medicare funds in the very near future. Senator Percy called for decisive action to create a stable and dependable Medicare system to assure aid to the elderly in the future. The Government must examine the options available and anticipate the problems created by a growth in the elderly population and the high cost of medical care. The Congressional Budget Office marked three areas of reform for Medicare: increase revenues by special taxation; increase beneficiary cost-sharing; or limit provider reimbursement. In this effort, there must be cooperation between the Federal Government, health care users, and health care providers.

Senator Percy requested that witnesses discuss the problems facing the Medicare system today, the advantages and disadvantages of various reform proposals, and the value of the prospective payment system.

THE COST OF CARING FOR THE CHRONICALLY ILL: THE CASE FOR INSURANCE, WASHINGTON, DC, SEPTEMBER 21, 1984, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

WITNESSES

Ella Thomas, Philadelphia, PA, accompanied by Brenda Rascher, caseworker, Philadelphia, PA.
Mary Kinslow, founding member, Children of Aging Parents, Levittown, PA.
Ron Hagen, coordinator, insurance division, American Association of Retired Persons, Washington, DC.
Betsy Houchen, director, Columbus Home Health Services, Columbus, OH.
Nancy Versnick, chairperson, LTC Insurance Task Force, American Health Care Association, Washington, DC.
Jim Sykes, chairman, Public Policy Committee, National Council on Aging, Madison, WI.
Barbara Matula, director, Division of Medical Assistance, North Carolina Department of Human Resources, Raleigh, NC.
Art Lifson, chairman, HIAA Task Force on Long-Term Care Insurance, Washington, DC.

ISSUES RAISED AND TESTIMONY SUMMARY

Chairman John Heinz called this hearing to examine testimony on the cost of caring for the chronically ill and to consider the possibility of insurance to protect Americans against the risk of a long-term illness. Long-term care is a tremendous threat to the financial security of older Americans, in particular because neither public health insurance programs nor private insurance policies adequately cover the unexpected costs of long-term care. Senator Heinz noted that many older Americans have just enough money to disqualify for Medicaid, but neither the money nor the insurance to cover their long-term care bills. Within a year, economically independent middle-income people will deplete their entire life savings and come to depend upon the Medicare Program.

The committee heard testimony from children of elderly parents describing the emotional and financial burden of caring for a chronically ill person at home. Mary Kinslow, founder of Children of Aging Parents [CAPS], described the efforts of the organization to help family caregivers provide for their chronically ill parents. A participant in Philadelphia's Channeling Project, Ella Thomas, discussed her family's difficulties in obtaining quality care at home without paying exorbitant prices. Ron Hagen of AARP explained the guidelines needed to establish long-term care policies and the problems involved in establishing this type of insurance, particularly the confusion of what the coverage would or would not entail. Art Lifson, representing the Health Insurance Association of America [HIAA], reviewed the possibility and the need for long-term care insurance for the future and stressed the importance of both public and private incentives to encourage the creation of long-term care policies.

DISCRIMINATION AGAINST THE POOR AND DISABLED IN NURSING HOMES, WASHINGTON, DC, OCTOBER 1, 1984, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

WITNESSES

Judy Moser, former nursing home admissions director, Madisonville, TN.
Julie Green, Sebastopol, CA.
Robert B. Snook, Bayville, NY.
Toby S. Edelman, staff attorney, National Senior Citizens Law Center, Washington, DC.
Stephen H. Sachs, attorney general, State of Maryland, Baltimore, MD.
Dr. Paul R. Willgin, deputy executive vice president, American Health Care Association, Washington, DC.

ISSUES RAISED AND TESTIMONY SUMMARY

The purpose of the hearing was to examine the increasing problem of discrimination in nursing homes against the poor and disabled. The high demand for nursing home beds enables nursing home administrators to favor private-pay over Medicaid-eligible patients. The committee found that many nursing homes demand substantial payments at private rates before they will accept a patient who is already eligible for Medicaid. Others refuse to admit so-called "heavy care" patients. These practices are illegal, yet often go unreported by families either because of their lack of experience with nursing home laws or because they fear the nursing home will retaliate by refusing to admit or retain the patient.

Senator Heinz called for the Department of Health and Human Services to begin enforcement of existing laws, including one which makes it a felony for a certified nursing home operation to solicit or receive funds "or other consideration" as a condition of admitting a Medicaid eligible person into a nursing home or as a precondition of the patient's remaining in one.

Testimony was heard from a former nursing home admissions director, and from family members of nursing home residents, who described the economic and emotional hardships created by illegal admissions practices. Maryland Attorney General Stephen Sachs explained a unique enforcement system which is utilized in his State, and stressed the need for Congress to enact more flexible sanctions. A representative from the nursing home industry discussed the reasons for discrimination, particularly stressing the "arbitrary" State efforts to limit nursing home bed supply. He disagreed with Chairman Heinz, who suggested the profitability of these practices functioned as an incentive to commit illegal acts.

WOMEN IN OUR AGING SOCIETY, COLUMBUS, OH, OCTOBER 8, 1984, HON. JOHN GLENN PRESIDING

WITNESSES

Robert Butler, M.D., Mount Sinai School of Medicine, New York, NY.
Dolores Snyder, Columbus, OH.

Marjorie Jenks, Columbus, OH.
Jeryl North, Columbus, OH.
Dr. Mildred M. Seltzer, Miami University, Oxford, OH.
Hon. Richard F. Celeste, Governor of Ohio, Columbus, OH.
Dr. Robert C. Atchley, Miami University, Oxford, OH.
Ella Holly, research associate, 9 to 5, National Association of Working Women, Cleveland, OH.
Dr. Jerome Kaplan, Mansfield Memorial Homes, Mansfield, OH.
Anna V. Brown, Department of Aging, Cleveland, OH.
Joyce F. Chapple, Ohio Department of Aging, Columbus, OH.

ISSUES RAISED AND TESTIMONY SUMMARY

Senator Glenn chaired this hearing in Columbus, OH, on October 8 to explore the issues that must be addressed to ensure that the younger women of today have a happier and more secure tomorrow than their mothers and grandmothers.

Senator Glenn stated that because women tend to live longer than men, the economic, health, and social problems of the elderly are primarily the problems of women. We must address the needs of today's older women, and we must determine what changes are needed in our current programs and policies to plan ahead for the 21st century. For instance, what changes are needed in our Social Security and pension laws to enable women, the majority of whom are now in the work force, to provide for their future retirement income security?

The committee received testimony from three Columbus women representing three generations of one family. They shared their life experiences and demonstrated that the aging of our society and the changing roles of women have an impact on health and social services, family and community life, and work and retirement.

At the hearing, Dr. Robert Butler, Mount Sinai (NY) Medical Center School of Medicine, emphasized why the problems facing older women are unique and important. He discussed the importance of biomedical research to improve the quality and quantity of life for the elderly, and the need to promote lifestyle changes that can prevent later chronic illnesses.

Other recommendations made by witnesses at the hearing include the following: First, provide additional job training opportunities for middle-aged women entering the work force; second, direct resources toward services for the frail elderly in their homes and communities and toward their family caregivers; and third, eliminate myths and stereotypes about the aged and women that persist in the medical profession, the work force and among the general public.

The hearing demonstrated the need for additional hearings and Senator Glenn announced his intention to hold future hearings related to the health care, work and retirement policy, and family and community life aspects of women and aging.

HEALTHY ELDERLY AMERICANS: A FEDERAL, STATE, AND PERSONAL PARTNERSHIP, ALBUQUERQUE, NM, OCTOBER 12, 1984, HON. JEFF BINGAMAN PRESIDING

WITNESSES

Samuel Lin, Deputy Assistant Secretary for Intergovernment Affairs, Public Health Service, accompanied by Virginia Thannisch, Health Care Financing Administration.
George Ellis, director, New Mexico State Agency on Aging.
Nina Mervine, State director, American Association of Retired Persons.
Peter P. Lamy, Center for the Study of Pharmacy and Therapeutics for the Elderly, University of Maryland.
Stephanie Fallcreek, director, Institute for Gerontological Research, New Mexico State University.
Pat Cleaveland, nutrition division, Department of Health and Environment, New Mexico.
Catherine Salveson, Department of Health and Environment, New Mexico.
James Goodwin, professor of medicine and chief of gerontology, University of New Mexico.
Larry Curley, executive director, Luguna Rainbow Nursing and Elderly Care.
Marjorie Trujillo, psychologist, Mental Health for the Elderly.
Thomas Follingstad, elderly outreach, Lovelace Medical Clinic.

ISSUES RAISED AND TESTIMONY SUMMARY

A field hearing was held under the auspices of the U.S. Senate Special Committee on Aging on October 12, 1984, in Albuquerque, NM. The hearing was conducted by Senator Jeff Bingaman, a member of the committee.

The first-of-its-kind hearing focused on health promotion and disease prevention among the elderly. Witnesses stated that the elderly comprise 15 percent of the population but account for one-third of all health care costs. The hearing proved that there is no doubt that the elderly are as interested in improving their health and in being fit as any group in our society. They are as willing as anybody else to make changes toward healthier lives. The main purpose of the hearing was to explore ways that Government can help them do that.

Dr. Samuel Lin discussed various efforts by the Department of Health and Human Services to promote better health for the elderly. A representative from the New Mexico State Agency on Aging, Dr. George Ellis, gave testimony concerning State initiatives, such as instigating nutrition programs, teaching health education and accident prevention, to encourage senior citizens to take an active part in their own health care. Nina Mervine explained AARP's campaign directed to their members which stresses not only the importance of an interest in personal health care but also involvement in State and Federal legislation which affects the health and well-being of senior citizens.

LIVING BETWEEN THE CRACKS: AMERICA'S CHRONIC HOMELESS, PHILADELPHIA, PA, DECEMBER 12, 1984, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

WITNESSES

Ronald Comer, Philadelphia Advocates for the Mentally Disabled, Philadelphia, PA.
Dr. John A. Talbott, president, American Psychiatric Association, New York, NY.
Dr. Harvey Vieth, Department of Health and Human Services, Washington, DC.
Leo Brooks, managing director, city of Philadelphia, Philadelphia, PA.
Sister Kathleen Schneider, Mercy Hospice, Philadelphia, PA.

ISSUES RAISED AND TESTIMONY SUMMARY

This hearing examined the condition of the aged and mentally disabled homeless, with particular reference to Federal involvement in combating this phenomenon. Testimony demonstrated that homelessness can no longer be viewed as a short-term problem, and that longer term solutions addressing the causes, rather than just the effects of homelessness are necessary.

Testimony was received from a set of homeless individuals who described their personal histories, and their experiences while homeless. Each witness pointed to the fact that for increasing numbers of Americans, affordable housing, adequate health care, and decent income are unavailable. Their testimony demonstrated the vulnerability of the chronic homeless, due to severe mental and physical handicaps, and the multiplicity of problems with which homeless individuals are often afflicted. This group also conveyed to the committee a sense of the fragmentation that marks the public assistance system designed to serve the disadvantaged, and the hostility these individuals frequently encountered from various Federal, State, and local service agencies. Ronald Comer, representing Philadelphia Advocates for the Mentally Disabled, testified along with the homeless people, translating their specific experiences into generalizations about the nature and extent of homelessness in Philadelphia.

Following the testimony of the homeless, a panel of four experts and public officials discussed alternative approaches to solving the problem. John A. Talbott, M.D., president of the American Psychiatric Association, outlined the recommendations of that organization's task force on the homeless mentally ill. He stressed the need to develop a comprehensive network of primary service that could be provided to the homeless to restore order, stability, and continuity in their lives. Dr. Harvey Vieth, Chairman of the Federal Interagency Task Force on Food and Shelter for the Homeless, testified on the activities of the Federal Government in addressing homelessness. He stressed that in the view of the administration, homelessness is a local problem and that Federal efforts should be directed at providing technical assistance to localities, and ensuring that homeless people entitled to Federal benefits receive them.

Leo Brooks, managing director for the city of Philadelphia, summarized the efforts of the city government in providing for the relief of the homeless. He urged that State and Federal Governments should play a larger role in solving homelessness, particularly through providing low-income housing. Sister Kathleen Schneider, administrator for Mercy Hospice, a small homeless shelter and rehabilitation center for women, testified on the need for leadership and decisive action to help the homeless. She underscored the magnitude of the problem, and the urgency of relief.

Supplement 2

COMMITTEE PRINTS AND REPORTS PRINTED BY THE SPECIAL COMMITTEE ON AGING IN 1984

1. DEVELOPMENTS IN AGING: 1983: VOLUME 1, FEBRUARY 1984.

2. DEVELOPMENTS IN AGING: 1983: VOLUME 2, FEBRUARY 1984.

3. MEDICARE: PAYING THE PHYSICIAN--HISTORY, ISSUES, AND OPTIONS, MARCH 1984.

4. OLDER AMERICANS AND THE FEDERAL BUDGET: PAST, PRESENT, AND FUTURE, APRIL 1984.

5. MEDICARE AND THE HEALTH COSTS OF OLDER AMERICANS: THE EXTENT AND EFFECTS OF COST SHARING, APRIL 1984.

6. THE SUPPLEMENTAL SECURITY INCOME PROGRAM: A 10-YEAR OVERVIEW, MAY 1984.

7. PUBLICATIONS LIST, MAY 1984.

8. LONG-TERM CARE IN WESTERN EUROPE AND CANADA: IMPLICATIONS FOR THE UNITED STATES, JULY 1984.

9. TURNING HOME EQUITY INTO INCOME FOR OLDER AMERICANS, JULY 1984.

10. THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: THE FIRST DECADE, AUGUST 1984.

11. THE COSTS OF EMPLOYING OLDER WORKERS, SEPTEMBER 1984.

12. RURAL AND SMALL-CITY ELDERLY, SEPTEMBER 1984.

13. SECTION 202 HOUSING FOR THE ELDERLY AND HANDICAPPED: A NATIONAL SURVEY, DECEMBER 1984.

14. PROTECTING OLDER AMERICANS AGAINST OVERPAYMENT OF INCOME TAXES, DECEMBER 1984.

Supplement 3

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Supplement 4

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REPORTS

Action for the Aged and Aging, Report No. 128, March 1961.**
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  Part 4. Washington, D.C., January 14-15, 1969.
  Part 5. Washington, D.C., November 20-21, 1969.

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  Part 4. Washington, D.C., homeownership aspects, July 31 and August 1, 1969.
  Part 5. Paramus, N.J., central suburban area, August 14, 1969.
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  Part 11. Washington, D.C., concluding hearing, May 4, 5, and 6, 1970.

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Occupational Health Hazards of Older Workers in New Mexico, Grants, N. Mex., August 30, 1979.**

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  Part 2. Washington, D.C., September 13, 1979.
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Minority Elderly: Economics and Housing in the 80's, Philadelphia, Pa., May 7, 1980.**

Maine's Rural Elderly: Independence Without Isolation, Bangor, Maine, June 9, 1980.**

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Impact of Federal Estate Tax Policies on Rural Women, Washington, D.C., February 4, 1981.***

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